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MENTAL NURSING



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MENTAL NURSING.

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# MENTAL NURSING

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## PREFACE.

THE following chapters, which first appeared as "Lectures" in the "NURSING MIRROR," are intended to give to a prospective Mental Nurse some idea of the work he or she contemplates, and to furnish those actually engaged in Mental Nursing with a practical guide in the nursing and management of the insane, without entering into academic details respecting the anatomy and physiology of the nervous system, which have no practical bearing on a nurse's work.

As most of the existing works devote too much attention to anatomy and physiology, and too little to the practical details of nursing, it has been felt that the present brochure supplies a want ; it has therefore been decided to publish the "Lectures" in book form.

W. H. B. STODDART.

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## CONTENTS.

CHAPTER.	PAGE
I. GENERAL AND MENTAL NURSING	9
II. HOW TO BECOME A MENTAL NURSE -	13
III. SOME COMMON SYMPTOMS OF INSANITY	18
IV. HABITS AND CONDUCT OF THE INSANE	23
V. SUICIDAL PATIENTS - - -	27
VI. STATES OF EXCITEMENT - - -	32
VII. VIOLENT PATIENTS - - -	36
VIII. DEPRESSED PATIENTS - - -	41
IX. DELUSIONS - - - -	46
X. EPILEPSY - - - - -	50
XI. GENERAL PARALYSIS - - -	59
XII. DEMENTIA - - - - -	63
XIII. IDIOCY AND IMBECILITY - -	67
XIV. FOOD AND FEEDING - - -	72
XV. BATHING AND HYDROTHERAPEUTIC MEASURES - - - -	77
XVI. URGENCIES - - - - -	81
XVII. CLEANLINESS, ORDER, ETC. - -	85
XVIII. GENERAL MANAGEMENT - - -	89
XIX. ENTERTAINMENTS. PRIVATE NURSING	93

## FOREWORD.

AMONG general nurses the word "nurse" implies female nurse. In the world of mental nursing, however, there are almost as many male as female nurses. For this reason I have been obliged to use almost invariably the pronominal forms "he", "his" and "him", not in the exclusively masculine sense, but to *include* "she" and "her".

There are five genders in English : Masculine, feminine, either, neither and both. "Man" is *masculine*, "woman" is *feminine*, "table" is *neither*, and "they" is *both*. When a man refers to a baby, whose sex is unknown to him, as "it", he uses the word in the *either* gender, not in the offensive *neither*, as the mother is apt to infer ; but it is never considered permissible to speak of an adult as "it". Whenever this is done, "it" is always intended as the offensive *neither*. It is to escape such difficulties, to avoid giving offence to anybody and to refrain from a constant repetition of "he (or she)" etc., that in these lectures, when the nurse is referred to as "he", the *either* gender is designated.

# MENTAL NURSING.

## CHAPTER I.

### GENERAL AND MENTAL NURSING.

Most people have had an opportunity of seeing the inside of a general hospital or at least they have a very fair idea of what it is like. On the other hand, very few people have even the foggiest notion respecting the interior of an asylum for the insane. If they have ever thought about the matter, they have conceived an asylum to be a barren, unfurnished, prison-like structure, whose "inmates" (not patients) are a number of noisy, screaming, destructive, murderous, foul and filthy creatures, who have lost all memory, do not know what they are doing and can never by any possibility recover from their malady. Moreover, they conceive the nurses to be somewhat of the nature of gaolers, but possibly rather more brutal and courageous, for they are to this day often referred to by the uninitiated public as "keepers" and the bedrooms of the asylums are called "cells". This popular notion that a patient suffering from mental disease is more or less of a criminal is exemplified by the attitude of a common jury towards a case of criminal assault on or criminal neglect of such a patient. Unfortunately, it sometimes—though, of course, rarely—happens that a nurse strikes a patient or, through neglect of duty allows him to commit suicide, and is therefore prosecuted by the asylum authorities; yet the jury nearly always acquits the nurse on the ground that the prosecution is a mere technicality, the idea at the back of their minds being that rough usage of an insane person is quite permissible.

Needless to say, these popular notions are the very antithesis of the truth. There are dangerous patients, it is true, but they are quite uncommon; it is years since we had one at Bethlem. They occur rather more frequently among the epileptic and criminal patients of county asylums. There are also noisy patients and dirty patients, but so there are in a general hospital. As to the asylum itself, it is not unlike a general hospital, and the present-day tendency is to make it more so. There are better decorations, greater comforts and more ground space, and the general hospitals might do worse than copy some of these asylum features.

Nevertheless, the above curious conceptions are widespread throughout the public mind and it is therefore not surprising that a youth or maiden seeking a livelihood should take to general rather than mental nursing, unless she has a friend who is able to tell her what the latter life is like; in which case mental nursing is usually selected. Indeed, whole families take to this life by preference. It is more healthy; most asylums are in healthy country districts, and even those in town have large grounds; more time is spent in the open air on duty and, as a rule, there is more time off duty. The remuneration is greater, both during the period of training and in private work; and if the asylum nurse elects subsequently to remain in the institution during the whole of her working life (usually till fifty-five years of age), she has a very fair guaranteed pension. On the whole, too, the nurses are better fed in asylums than in general hospitals, and there are more entertainments. Moreover, there is less risk of unemployment in mental nursing; the cases are usually of longer duration, and a good mental nurse, especially one of good social status, is always in demand. Physicians in consulting practice frequently have to employ ladies of extremely limited experience of mental work because there is an insufficient supply of trained mental nurses engaged in private work. We want more!

Another reason why general nursing is adopted in preference to mental nursing is that the latter is a speciality, and it is quite rightly held that general training should precede specialism. In this respect mental nursing stands in rather a peculiar position, for a nurse undergoing training in a general hospital has the opportunity of obtaining instruction in every branch of nursing except insanity. In this respect a general nurse's training is invariably incomplete; and, unless she happens to be a woman of remarkable insight, the deficiency is shown in her work.

There are nearly always strained relations between a patient suffering from advanced phthisis and his nurses, because these are unable to understand and make allowance for his irritability. The apprehensiveness of patients with exophthalmic goitre is regarded as nonsensical stupidity, and not infrequently they are upbraided for what is in reality a symptom of their disease. Patients with Bright's and cardiac disease have attacks of depression and excitement, largely dependent on alterations of blood-pressure, so they are regarded as "moody" or "nasty" and a sudden decision on their part to take their premature discharge in a fit of pique is welcomed instead of being treated as a symptom.

On the other hand, if a patient in an asylum complains of pain on account of an attack of pleurisy, the mental nurse is apt to say that it is the result of hysteria; an attack of sickness from gastritis may be looked upon as a voluntary attempt to reject food, and the nurse would like to give the patient another meal; the dangers of sepsis are not realised by the average mental nurse, and a smear of vaseline is considered correct treatment for a fresh cut or an open sore. The present-day mental nurse is not quite so bad in these respects as her predecessors, but the same kind of thing sometimes occurs even now.

Of course, a mental nurse has no idea of general nursing, and a general nurse is at her wit's ends if she

comes across a thoroughgoing lunatic. The natural conclusion, then, is that every nurse should receive both a general and a mental training. This, of course, means devoting six or more years to training; but it will not be considered a serious matter when it is remembered that a mental probationer receives a very fair wage from the day he or she enters the asylum. Moreover, those who are looking to the future will do well to reflect that there is a growing tendency on the part of the asylum authorities to select as matrons ladies who have had the double training.

There is some diversity of opinion as to the proper order. Should the asylum or the general hospital come first? Personally I am inclined to vote for the asylum, because the mental nurse has much more responsibility (not, of course, at first) and has to use her wits so much more than a general nurse. A general nurse has to do merely what she is told and her training consists of teaching her how to do it; and my experience of the hospital-trained nurse in an asylum is that she is too much afraid of acting on her own initiative in matters of urgency. Incidentally, too, she seems to have a remarkable facility for "treading on the toes" of the other nurses. My recommendation is, then, three years' mental training, three years' hospital training, then back to an asylum. You may have to start at the bottom of the ladder again; but it does not matter, for you are sure of rapid promotion and, by the time you are thirty-five, you will be fairly certain of one of the best-paid matron's posts in the country with a good pension at the end of it. If, on the other hand, you elect to go in for private nursing, you are in a very strong position.

In some districts an excellent agreement exists between the local hospital and asylum, whereby a hospital nurse may receive one year's training at the asylum and *vice versa*; and I see no reason why this arrangement should not become universal.

## CHAPTER II.

### HOW TO BECOME A MENTAL NURSE.

IN the first chapter I have recommended mental nursing as a career ; but I must now utter a word of warning that it is by no means every person who is adapted to such a profession, and those who contemplate entering it should make a preliminary survey of their own character.

Good mental and physical health are essential. By this I do not mean that a mental nurse must have a domineering character and the muscular strength of a horse, but merely that he should not be liable to mental or physical illness. He (or she) should not be over-sensitive, nervous or fussy ; for, on the one hand, he must remember that his future patients are at times apt to be exceedingly irritating, and, on the other, that a fussy nurse is exceedingly irritating to patients.

He should be good-tempered, gentle, tactful, sympathetic and free from that common tendency to laugh at other people's misfortunes and to "poke fun" at other people's fancies. He should have a natural inclination to be attentive to others. He should be punctual and zealous in the performance of duties, and keen on whatever he undertakes. Loyalty to superior officers is an essential quality. It is desirable that he should be observant and have a natural insight into the character of other people, although he will learn this in the course of his training ; and he should be ready in emergency, quick to act and not too deliberate.

It is clear that such a person will be particularly enthusiastic respecting the more academic aspects of

the work ; but he must also be willing to enter into the amusements of the patients and to entertain them and, if he can play and sing well, so much the better.

Nobody can ever hope to become a mental nurse who has not some pretence to education, for the examiners of the Medico-Psychological Association are getting more and more particular in excluding from the certificate candidates whose writing, spelling, or modes of expression in their answers are faulty, quite apart from the amount of knowledge exhibited. When I was superintendent of Bethlem Hospital, one of my candidates—an excellent nurse—was periodically rejected on account of his bad spelling. He endeavoured to overcome his difficulty by attending night classes, and the matter of his answers was quite good ; but to this day he has never passed the examination and, consequently, in accordance with the rules of the hospital, has not been promoted to any senior post. Moreover, a mental nurse, much more than a general nurse, in private work has to mix with the family and have meals with them, sitting next to the patient, and it is natural that they should insist on an educated and refined man or woman to occupy such a position.

The prospective mental nurse must remember that during the period of training he has to live with a community of other nurses. He must, therefore, have the faculty of making friends. Otherwise he will soon find himself in the intolerable position of being “left out in the cold”. Lastly, he must have no “skeleton in the cupboard”, nothing of which he would be ashamed for his colleagues to know respecting his parentage or past life ; for a community of nurses has a remarkable facility of finding out all about one another, especially items they are not intended to know.

Perhaps I have made the preliminary examination a little severe, but it is left to each individual himself to decide whether he will pass or not. If he is successful, the next matter for consideration is the choice of an institution for training.

### THE MEDICO-PSYCHOLOGICAL EXAMINATION.

In the mental world there is only one recognised qualification, viz., the nursing certificate of the Medico-Psychological Association of Great Britain and Ireland. It is the one-portal system, and no asylum is authorised to grant a certificate of its own.

In order to qualify for this certificate every nurse must pass two examinations, the preliminary (at the end of not less than one year of training) and the final (not less than two years after passing the preliminary). The course for nurses with a general training is somewhat shorter. Further, the nurse must produce a certificate that he has attended a certain number of lectures and test examinations. The preliminary is in anatomy, physiology and first-aid ; the final is in mental nursing proper and the examinations are held twice a year. Arrangements are made for these lectures and test examinations in most institutions and the nurse who is anxious for ultimate success should be careful to attend every one of them.

Of course, some nurses fail in these examinations through lack of knowledge and insufficient study of the official Handbook of the Association ; but, in my opinion, by far the majority of failures are due to the candidates' inability to express his knowledge in writing. Nurses should remember this and seize every opportunity of practice in expressing themselves in writing. Ordinary correspondence with friends is very good for this purpose. If a colleague asks a question about the work, let him say, " I will write it out for you " and do so accordingly. Mr. Macphail has published a little book entitled " Model Answers to Questions set by the Medico-Psychological Association " ; it is published by The Scientific Press, Ltd., and is well worthy of study.

### CHOICE OF AN INSTITUTION.

From what has been said it is clear that a prospective mental nurse should select as her home for training

an institution recognised by the Medico-Psychological Association, where lectures are given and nurses are trained for the examination. Such institutions are usually county or borough asylums; but if possible it is better to select some establishment for the treatment of the better classes. These are either recognised "hospitals" for the insane or large private asylums, where the patients are much more interesting and the nurse is brought into contact with such cases as he will later encounter in private work. If massage is taught, so much the better.

Another point to be considered is this: in some institutions the menial work—scrubbing the floors, blacking the grates, etc.—is done entirely by the nurses. Other establishments employ wardmaids, while in the public asylums a number of the chronic patients are employed, with benefit to the asylum as well as to themselves, in doing such work. I am not much in favour of professional nurses having to perform these duties, and the custom of the establishment which the nurse proposes to enter should be investigated.

Further, the nurse should remember that the course of training will last for three or four years and, therefore, in selecting an institution, have an eye to personal health and comfort. He should ascertain that the superintendent, head attendant and matron are popular; and it is desirable, from a nurse's point of view, that neither of these officials, nor the asylum itself, should be too old. There should be a nurses' home. The feeding and salary should compare favourably with those of similar establishments and the applicant should be satisfied that the general health of the nurses is good.

He should also bear in mind the possibility—even the probability—that he may subsequently prefer regular institution employment and work to the more precarious occupation of private nursing, and he should select an institution in which a pension is assured and promotions are preferably made according to merit rather than age, but without any sign of favouritism.

The next point I wish to mention is very important and I had intended to refer to it earlier. The asylum should be within easily accessible distance of the nurse's own home, so that he has friends to visit when he is off duty; and, moreover, he should always make a point of doing so, both for his own benefit and for the sake of his patients. Many old nurses, especially female nurses, who are necessarily unmarried and have no such home ties as the married male nurses, are liable to get into the habit of spending their off-duty time in their own rooms or with friends in other wards of the asylum. In thus separating themselves from the outside world they are not fair to themselves or their patients. They become "asylumised". Only those of my readers who are already familiar with asylum life will know the meaning of this word; others must simply take the warning not to fall into the error. The nurse is the chief representative of the outside world to his patients and his off-duty time ought to enable him to take something (an indefinable something of his unconscious freshness) back to them.

Lastly, let me say that a mental nurse should not consider himself fully trained as soon as he has passed the Medico-Psychological examination. The whole of the first three years is spent in junior, irresponsible posts of the institution and his interests are centred on obtaining the qualification; but during the fourth year he is given more responsibility and enabled to study in his own way the idiosyncrasies of patients from a practical point of view. I recommend, therefore, that a prospective mental nurse should look forward to spending a period of four years in his selected home of training.

It need scarcely be said that an institution fulfilling all the above-mentioned conditions does not exist. The nurse will see for himself that some of the requirements are more important than others; and it must be left for him ultimately to decide whether the establishment in which he proposes to train approximates sufficiently to the ideal.

## CHAPTER III.

### SOME COMMON SYMPTOMS OF INSANITY.

WE have to recognise that there are two distinct aspects of mind or mentation—namely, a receptive and an executive. The former includes such faculties as feeling, seeing, apprehending, believing and remembering; the latter implies conduct, behaviour and action and includes speech, gesture, attention and emotional expression. It has sometimes been pedantically argued that insanity is disorder of conduct and that disorder of the receptive faculties does not constitute insanity. Quibblers, who maintain this proposition, would say that a man who believes himself to be the Emperor of China is not insane unless he says so or behave as if he were such a personage. Followed to its rational conclusion, such a view would imply that our efforts to cure an insane patient should be directed merely to improving his behaviour and that we ought not to trouble about such symptoms as delusions and loss of memory. It is quite true that disorders of conduct are the symptoms which give most trouble to the nurse; but, being an intelligent individual, anxious for the recovery of his patient, he will also be particular to note other symptoms which occur during the doctor's absence and report them to him on his round. Accordingly, in the present lecture a brief description is given of some of the more important symptoms of disorder of the receptive faculties of mentation.

If a plate of food is placed before you, you know that it is a plate of food through sensations of sight, feeling, smell, taste and, in some instances, even hearing. This

faculty is called "perception" and, according to the particular sense-organ through which the perception is made, it is known as visual perception, tactile perception, olfactory, gustatory or auditory perception. Examples of visual and auditory perception respectively are the understanding of written and spoken language.

Now in some patients one or more of these varieties of perception may be absent or destroyed. They can see, feel and smell the food, but the sensations have no meaning for them and they cannot tell that it is food. This is "imperception" or "agnosia", the recognition of which will enable the nurse to understand a multiplicity of symptoms. It explains why such a patient does not obey orders (he does not understand them—you might just as well be talking Greek to him); it explains why he does not recognise his friends when they call; it explains why he does not know where he is and cannot find his way; it explains why he is dirty in his habits (he does not apprehend the nature of the sensations which should induce him to retire to the w.c.); it explains why he does not take food when it is placed before him, and the nurse would be wrong who reported that the patient had *refused* food.

If the patient is slightly less confused than this, so that the appearance of the plate of food is not entirely meaningless to him, so that he endows his visual sensations with a certain content, albeit the wrong content, so that he mistakes the plate of food for his hat and accordingly empties it over his head, he has had an "illusion". How wrong it would be for the nurse to blame the patient under such circumstances for wilful perversity.

Illusions are quite common among the insane. The above would be a visual illusion. The commonest example of a gustatory illusion is the case of a patient with decayed teeth or a disturbed digestion, and consequently a filthy mouth, who believes that poison is put in his food. As an example of an auditory illusion I may cite the case of a man who mistook the noise of another patient breaking wind for his wife's voice.

The last disorder of perception I shall mention is "hallucination". Here there is a complete absence of sensory stimulus, yet the patient experiences a perception. In the darkness and silence of the night, for example, he sees faces or hears voices (visual and auditory hallucinations). Gustatory, olfactory and tactile hallucinations also occur. This is a state of affairs we can all appreciate, for we experience them ourselves in dreams and especially during the hypnagogic state (state between waking and sleeping). I have given nocturnal hallucinations as an example, but it must be understood that they occur as frequently during the day.

I will next attempt to explain what a delusion is. When a person makes an assertion respecting something or somebody—for example, "a pipe is in my mouth" or "John Smith is my friend"—that is a "proposition". If he makes such a proposition and believes it to be untrue, that is a "lie" or "falsehood". If he *thinks* "a pipe is in my mouth" or "John Smith is my friend" and such statement is true, that is a "judgment". If he *thinks* these assertions to be true, and they are false, he is suffering from a "delusion".

Not all delusions, however, are signs of insanity. An insane delusion has been defined as "a judgment which cannot be accepted by people of the same class, education, race and period of life as the person who expresses it". The mariner thinks that it will bring him bad luck to shoot an albatross; the uneducated think that it brings bad luck to spill salt; certain Indians believe that thunder and lightning are the clang and glitter of the bracelets of a beautiful goddess dancing with delight at the coming of the rain; and a child believes that her dolly is sick; but these people are not therefore insane. These are sane delusions.

The number of insane delusions is so numerous that it would serve no useful purpose to attempt to enumerate or classify them; but, whatever may be a patient's delusion, it should never induce the nurse to laugh at the patient. Indeed, it is better at first not even to

contradict or disregard a delusion, and the nurse will gain the confidence of a patient more readily by listening sympathetically to him and endeavouring to see matters from his point of view. By doing this he will be able to help the doctor to understand and treat the case. It is, of course, not necessary to agree with every word the patient says; a nurse can easily get out of a difficulty by saying, "What you say seems reasonable from your point of view, but I should like to think it over", or words to that effect. After two or three weeks, when he has gained the patient's confidence, he may begin to point out minor instances in which the patient *may be mistaken*. This attitude should be continued for many weeks, perhaps months, taking care never to contradict the patient directly or to attack the main delusion. The rule, as in golf, is "Don't press". Use the utmost patience and tact not to lose his confidence, and your patience will some day be rewarded with an opportunity to attack the main delusion by remarking, "It seems to me that you may even be mistaken in this matter too; I should advise you to talk it over with the doctor".

I need refer but briefly to the disorders of memory. The chief of these is "amnesia", or loss of memory. The loss is almost invariably for events of recent occurrence. The patient is unable to tell the date, in some cases even the month or year, and he cannot remember what he had for his last meal. Stories of long ago he can relate with detail. All that the nurse can do in such cases is to help the patient when his memory is at fault.

In a few cases of mania and idiocy (mental defect from childhood) there is a remarkable exaltation or excess of memory. It is called "hypermnnesia", and is usually somewhat limited in its range. The patient can tell, for example, what he was doing on any given day years ago, or the date of any event about which he has ever read, or the duration of residence of any nurse in the asylum. The symptom has little interest from a nursing point of view.

“Paramnesia” is a symptom which occurs in some alcoholic patients and in certain senile cases. Such patients “remember” events which have never occurred, or they *recognise* a place—the asylum, for example—in which they have never been before. The symptom, however, has also little more than academic interest for the nurse.

## CHAPTER IV.

### HABITS AND CONDUCT OF THE INSANE.

I WAS once going through one of the wards of a mental hospital where the sister was off duty and the senior nurse was left in charge. One of the patients was wandering all over the ward in a serpentine fashion, and was being followed by one of the junior nurses, who was trying to induce the patient to sit down ; and I overheard the senior nurse whisper to her colleague, " Let her alone ", intending that neither I nor the patient should hear her remark. I made a mental note of the incident, and determined to promote that nurse as soon as opportunity should arise. The patient was doing no harm to herself or others ; while the nurse had grasped the principle of non-interference, and endeavoured to teach it to her junior without minimising her authority.

In dealing with the habits and conduct of the insane, often of a most extraordinary character, the nurse has to decide, frequently on the spur of the moment, whether a particular action is likely to have any detrimental effect on himself or others. If not, he should leave the patient to his own devices, for interference only irritates a patient ; if it is detrimental, it should be tactfully checked, restrained, repressed, reprimanded or forbidden.

Motor restlessness or excitement (I shall have more to say about this in a subsequent chapter) is a symptom to be dealt with. The nurse can obviously do nothing to prevent the brawling, screaming and aimless activity of a patient who is mentally confused (certain alcoholics, for example). The doctor will probably prescribe some sedative medicine for such a case, and all the nurse can do is to administer it. The nurse can, however, use his influence to curb noisiness, excitement, mischief and

practical joking of a maniacal patient who knows perfectly well what he is doing.

The reverse of such conditions—inactivity with absence of speech and voluntary movement—occurs in depressed patients who are, as it were, paralysed by a sense of fear or some allied emotion, or in patients who are motionless and silent on account of some delusion. Also in those in whom the inactivity is meaningless and only indicates a tendency to retire from the world of reality, as in dementia præcox, into a world of the patient's own unconscious creation. Attempts to "rouse" any of these patients are to be deprecated. In the first class the inactivity is Nature's suggestion as to a remedy for the disease, and such patients should be in bed; while the other two classes are only irritated by interference. There is no objection to a non-resisting patient being taken for a gentle walk round the garden on a cold day between a couple of nurses in order to promote his circulation; but if there is much resistance, and the walk resolves itself into a constant struggle, the circulation of the nurses will be promoted more than that of the patient, and no benefit can accrue to a single member of the group.

Many of the chronic patients have a habit of collecting all sorts of rubbish and, inasmuch as they consider their various collections to be of some value, they naturally resent a clearance. This, however, becomes an absolute necessity from time to time, if only for sanitary reasons; and it *must* be done, even at the expense of offending the patient. Here a white lie is permissible to avoid friction and it may be suggested that it would be safer to take care of the valuables in a more secure part of the building; "besides, the collection is growing so fast that room will be required for more". There is usually trouble in such cases, but it soon blows over.

Food is a common difficulty and I shall have to devote a special lecture to this matter. Many patients refuse food; others (especially hypochondriacs) eat too much; others, again, eat all sorts of filth. When I was

pathologist at Prestwich Asylum I obtained from one patient on *post-mortem* examination a complete cast of the stomach in hair, coir, tape and such materials. The nurse's duty with such patients is obvious.

Many patients suffer from a veritable washing mania. They would wash their hands all day long if they were allowed. The symptom is usually symbolic of a desire to wash their minds. The skin of their hands suffers if these patients are permitted to indulge in their idiosyncrasy and they must therefore be prevented; but I should like to take this opportunity of saying that it does not therefore follow that no patient should be allowed to wash his hands except at specified times. Most normal people of the better classes like to wash their hands before meals or after retiring to the lavatory and it is unnecessary tyranny to prevent them from doing so.

Masturbation is an unfortunate but common habit among the insane and the nurse should do all in his power to check it. I regret that I have no recommendations to offer. Drugs afford a possible remedy; but they are by no means certain; and I can only suggest that a patient addicted to this habit should be in the public gaze as much as possible, unless, of course, he is so lost to shame as to masturbate in public. Most patients worry considerably about such a habit, although they do not appear to do so, and it is not wise to alarm them about it by telling them, for example, that they will never recover as long as the habit persists. Worry is provocative of masturbation, which seems to serve as a kind of solace, and I think that, on the whole, it is more judicious to tell a patient not to worry about it, perhaps even to say that it does not matter.

Negativism, a peculiar symptom which occurs especially in dementia præcox, is a tendency in certain patients to do exactly the opposite of what is required of them, even the opposite of what they wish to do themselves. They will, for example, refuse food when they are intensely hungry, or cause themselves discomfort

and pain by retaining their fæces and urine. I cannot here enter into the psychology of the condition, but nurses must realise that this symptom is not wilful perversity or obstinacy. The patient cannot help it.

Incoherence is a disorder of speech in which any person listening to the patient is unable to follow his train of thought; but it must be remembered that such patients are, as a rule, not incoherent to themselves. The symptom is due to the fact that the thoughts flow too rapidly to find expression in speech. Incoherence is sometimes very important, inasmuch as it frequently gives a clue to an attentive listener to some unconscious worry which is the real cause of the patient's illness. If the nurse is able to communicate to the doctor information gleaned from such sources, it may enable him subsequently, on recovery from the attack, to set the patient's mind at rest, so as to avert a recurrence.

Many patients write rubbish, absolute rubbish, from morning till night every day, week in and week out, and they waste an enormous lot of paper. Why should they not? It relieves their minds, and paper is cheaper than medicine. Let them have it.

Mental nurses of experience will naturally think of many other common habits of the insane and young nurses will soon learn them. Suicidal tendency, for example, is so common that I devote the whole of my next chapter to it. Here I mention the stuffing of key-holes, etc. to keep out noxious gases, the setting of traps for imaginary persecutors and the wearing of fantastic dress and self-conferred decorations, merely to say that all such habits should be discouraged, as they tend only to confirm a patient's delusions. Moreover, such insane activities constantly impress upon other patients the fact that they are in an asylum, being herded with "lunatics", a most undesirable result, at least from the friends' point of view. For similar reasons, nicknames such as "Her Majesty" or "The General" should not be used by the nurses and should be discouraged among the other patients.

## CHAPTER V.

### SUICIDAL PATIENTS.

AMONG the general population suicide appears to be taken much less seriously than in the lunacy world. Most people seem to have very little sense of responsibility towards a person who is so depressed as to have given expression to the view that his life is not worth living. Even some doctors assume the responsibility of a suicidal patient in a most light-hearted fashion. The consequence is that we read almost daily in the newspapers of a coroner's jury returning a verdict of "suicide while of unsound mind".

On the other hand, a suicide in an asylum is regarded throughout the lunacy world as more or less of a disgrace, and the staff of the particular institution is in a state of depression and anxiety for days and weeks after the occurrence, even among those who did not know the patient. Doubtless this is fostered by the penalties to which a careless mental nurse is liable should his carelessness lead to such a catastrophe. He is discharged from the asylum without a character and reported to the Board of Control, which enters his name in a black book, so that he may never more be engaged in mental nursing, and he is prosecuted in a court of law for criminal carelessness, and may be sentenced to a term of imprisonment.

Considering the enormous number of suicidal patients who pass through the hands of mental nurses, it speaks volumes for the character of their work that suicides in asylums are so infrequent.

The instinct of self-preservation is implanted so strongly in every one of us that the question naturally

arises, " Why do so many of the insane desire to commit suicide ? " The reasons are many ; here are some of them. They feel unfit or too miserable to live, they have to bear the sins of the whole world (a sort of martyrdom), they are in constant fear of contaminating others with their misery or with some supposed disease, they are dead already and wish to get rid of the body (such patients are liable to throw themselves into the river), they desire to escape some imagined system of persecution ; " voices " tell them to do it ; they commit suicide on the impulse of the moment for no reason whatever, or they do it by accident by attempting some impossible feat, such as jumping out of a third storey window for purposes of escape.

There is no variety of mental disorder which may not lead to a suicidal tendency, but it occurs pre-eminently in melancholia. Every person who becomes profoundly depressed must be regarded as a possible suicide ; about four out of every five melancholiacs are more or less actively suicidal, and about one in every twenty is dangerously so.

We have to recognise several degrees of the suicidal tendency. Some patients are so determined that they spend their whole time, attention and watchfulness in seeking death by any possible means. Others are just as determined, but have set their mind on some particular means ; a patient of this class who, for example, has set his mind on plunging some sharp instrument into his heart is unlikely to hang himself. Of first importance are patients who have already made a definite attempt at suicide ; and I include as " attempts " the secreting of cutting or stabbing implements or of cords or tapes about the person or bedroom or in the bedding, and attempts to slip away from the nurse in charge, unless for purposes of escape or practical joking.

Then there are the patients who have expressed a wish to die, or say that life is not worth living or that they are of no use in the world, or ask to be given an overdose of their medicine. Such cases are not regarded as actively

suicidal, but they give considerable cause for anxiety and require incessant and watchful care. It is generally held that the more a patient talks about suicide the less he is likely to do it, but this rule must not be taken so seriously as to lead to dangerous relaxation of vigilance.

Little notice need be taken of impulsive threats of suicide made by patients merely because they are not allowed to have their own way in some trifling matter, but it is injudicious to disregard them completely. It is well to treat such patients for a few days only as being suicidal.

In institutions for the insane as much as possible is done to minimise the risks of suicide, and when a nurse has charge of a patient in private she must see to it that the same principles are carried out. The windows are so constructed or blocked that no patient can get through them, possible points of suspension are placed out of reach or covered in, locked guards are fixed in front of the fireplaces, there is no lock or bolt on the door of the w.c. ; the friends of patients are all forbidden to introduce knives, scissors, or other such implements, or to leave bottles of medicine with the patients ; knives and forks are kept under lock and key and are always counted immediately before and after use, and clothes are removed from the patient's bedrooms at night, when even handkerchiefs are forbidden. Yet all these arrangements are useless for the prevention of suicide unless the one essential specific treatment of suicidal patients is strictly carried out, viz. constant personal supervision. Never for a single moment, night or day, must he be left alone, not even in the w.c. If he be watched ever so assiduously for the whole of the twenty-four hours, for a whole week, for a whole month, and then be left for one instant while the nurses are changing duty (an especially dangerous time, especially in the early morning), that instant is fatal. The suicidal tendency, as a rule, is not quite so strong during the later stages of an illness as during the first few months, and after a year

or more supervision need not be quite so strenuous as at first ; but it must still be constant.

In the majority of cases, of course, the vigilance may be relaxed long before this, but it takes an experienced doctor or nurse to decide when it is safe to allow the patient to be alone for a while. Personally I never rely on my own judgment alone, but always ask the nurse his opinion on this matter, and I permit relaxation only when we both agree that it is safe. At the same time, we have to recognise that it is irritating and detrimental to a patient unnecessarily to prolong our mistrust of him.

There is one patient out of about every two hundred admissions who is so desperately suicidal as to require the sole attention of a nurse (usually called a "special"), who must never be more than a few feet away and must never take his eyes off him. Whereas with most suicidals some endeavour is made to render perpetual observation as unobtrusive as possible, so as to give them an opportunity of forgetting it, no such quarter is allowed the most determined cases. Not only must the nurse be constantly alert, but the patient must know and feel that this is the case. Suicide is an idea always present in his mind and the only antidote is a never-changing idea of impossibility.

The usual system adopted in asylums to warn nurses that such and such a patient is suicidal is that a "parchment" or "ticket" is issued to that effect, which has to be signed by all the nurses who are likely to have charge of the patient. The form is somewhat like this :—

(NAME OF INSTITUTION).

Take notice that *John Smith* is suicidal.

He has threatened suicide by *hanging*.

He has attempted suicide by *strangulation*.

He must therefore be kept under constant observation.

(Signed) X.Y., Medical Superintendent.

I have read the above warning and understand it.

(Signed by *the nurses severally*).

It is also a good system to issue a small celluloid or xylonite disc on which is written the patient's name. The nurse who has possession of this disc is held responsible for the patient's life. If the nurse has to leave his ward, he hands this disc to another nurse, who should see that he has the several patients in view before accepting the discs.

No nurse should accept the responsibility of too many suicidal patients at the same time, so that vigilance can become practically impossible; for example, by the patients walking off in different directions. Moreover, no nurse should be "special" on a case for more than two hours at a time, except perhaps at night, when the patient is asleep. Otherwise the work becomes too exhausting to be efficient.

No asylum is so constructed as to render self-destruction impossible. To do this would be to make the establishment so intolerable that death itself would be better than life in such a place. Rather than make the environment of patients so unbearable, justifiable risks are run every day and accidents consequently occur from time to time among cases of unsuspected suicidal tendency and among patients who have been suicidal, but are believed to have recovered and are therefore exempt from special observation. In connection with such suicides, no blame is to be attached to anyone; but the experienced nurse is always suspicious of the happy smiling face that conceals a heavy heart. Be especially watchful over such patients and also over convalescent patients who are looking forward to their return to a miserable, wretched and distressing home life.

## CHAPTER VI.

### STATES OF EXCITEMENT.

WHEN a normal healthy individual tells you that he or she feels excited there is usually very little display of motor agitation or emotional expression. With mental patients on the other hand, especially those suffering from the more acute or severe forms of insanity, there is considerable inability to control the emotions and the result is that an attack of excitement in an insane person presents a picture which almost conforms with the popular notion of a "lunatic". Such patients shout, sing, make wild rushes, wave their arms, tear their clothing, smash windows or vases and sometimes even strike other people.

Excitement may, of course, be expressive of many emotions, such as joy, hilarity, resentment, anger or an intense fear of danger. It occurs in a variety of mental disorders, the chief of which are mania, confusional insanity (including delirium tremens and the delirium of fever), epilepsy, general paralysis and dementia præcox.

Mania may be described as a state of excitement pure and simple. The patients are intellectually clear, they know quite well what they are doing; other symptoms, when present, play quite an unimportant rôle, and loss of control of the emotions is to be regarded as the chief characteristic of the disease.

In confusional insanity, on the other hand, there is clouding of consciousness, often with profound loss of memory, the patient being frequently unable to tell where he is or even his own name and identity; and there are almost invariably hallucinations of sight

(usually faces) and hearing (usually voices). It may therefore be taken as a general rule that the excitement of these patients is the result of some confused idea they have in their minds.

Probably the most intense excitement ever encountered in an asylum is that associated with epilepsy, one variety being so severe as to have earned the name "epileptic furor". The excitement may last from a few hours to a few days and indicates the approach of a convulsion, replaces a convulsion or, less frequently, follows a convulsion. Some patients are also excitable between their convulsive attacks and require careful and tactful management to avoid the onset of definite excitement.

Some general paralytics, during the earlier stages of their disease, are liable to very severe attacks of excitement. Indeed, the most dangerous patients I have ever come across have been patients of this class. Fortunately, the excited variety of general paralysis is rather uncommon. The disease usually manifests itself by a brief delusional period, followed by progressive dementia, which terminates fatally in about a couple of years; but the excited variety usually lasts much longer, and the patient has several intervals of comparative health before a fatal termination ensues.

Dementia præcox is a protean disorder which makes its appearance most commonly during adolescence, its chief characteristic being perhaps a retiring, seclusive disposition on the part of the patients. This disposition gradually becomes more and more marked as the disease progresses until, by the formation of numerous hallucinations and delusions, disordered activities and restraint of activity, the patient retires into and lives in a world of his own unconscious creation. Excitement is not commonly a characteristic feature of the disease, but the patients are liable to become excited, perhaps for days, as the result of the most trifling interference on the part of a nurse or another patient.

Excitement may take the form either of noisiness or of motor agitation and restlessness and, from a practical point of view, may be divided into avoidable and unavoidable excitement. The excitement caused by terrifying hallucinations or occurring as a symptom of epilepsy is the direct result of the disease, and the nurse can do nothing to prevent it ; but in the majority of cases an attack of excitement can be traced to a definite cause and a nurse should never be satisfied until he has discovered the cause. Sometimes this is of a physical nature, such as the pain from a decayed tooth or the pangs of hunger or thirst or it may even be nothing more serious than the expression of a desire for a cigarette.

On the other hand, it will quite commonly be found that the patient has been annoyed in some way. He has been struck by another patient or a nurse has refused some request in a tactless way or even had a mild quarrel with him. Of course, such incidents ought not to occur at all ; but if they do, it is much easier to calm the patient if you can find out what has excited him and can see matters from his point of view. I have cited epilepsy and hallucinations as unavoidable causes of excitement ; but this does not mean that a nurse is to be satisfied with the explanation that the patient is an epileptic or suffering from hallucinations ; he should try to discover, even in these cases, whether a given attack of excitement is due to some external cause or not. This systematic search for the causes of excitement will teach the nurse the various idiosyncrasies of his patients and thus enable him to prevent the recurrence of attacks. It will, moreover, frequently indicate which of the other nurses are tactless in their management of patients.

*Noisiness* is a particularly troublesome form of excitement, for every mental nurse knows how contagious it is. A single noisy patient in a ward will start half a dozen others being noisy. To avoid such contamination there is in each ward of most asylums a

room to which a noisy patient may be removed. This should always be done at once, without a moment's delay ; but there should not be the slightest hint of disgrace or punishment associated with such removal. It should rather be suggested that the room is a place of retreat from the annoyances of the general ward ; and I would have it furnished a little more artistically than the general ward, so as to encourage the idea among patients that it is a sort of infirmary. If there are a few beds therein, and even a padded room leading off from it, so much the better.

As I have just said, noisiness is contagious among the insane and it behoves the nurses to set an example. Nurses should be particularly quiet in a ward in which there are excitable patients, and should at least *appear* to go about on tiptoe. Rubber heels should be compulsory. Of course, requests and orders should not be shouted about the ward ; this in itself would be quite a sufficient excuse for noisiness among the patients. A noisy ward is a mismanaged ward.

Noisiness is but a special variety of excitement, and whenever it occurs the same principle of searching for a cause applies.

There are, of course, many other methods of treatment of excited patients, such as drugs and prolonged baths ; but as the prescription of such measures lies within the jurisdiction of the medical officer, I say nothing about these in a handbook intended for nurses.

## CHAPTER VII.

### VIOLENT PATIENTS.

IN a well-managed asylum violence is much more uncommon than is popularly supposed. For the most part it is due to preventable causes, but occasionally it is the direct result of the patient's disease.

The two chief preventable causes are overcrowding and interference. Those who have much occasion to walk along the crowded pavements of Oxford Street can appreciate how very irritating it must be to a nervous patient to live constantly in a similar crowd, from which he is unable to get away. The obvious remedy (plenty of floor-space in asylums) lies beyond the jurisdiction of the nurse ; but there is no objection to his making the suggestion to a responsible and sympathetic medical officer that such and such a patient might be less irritable in a less crowded ward.

The other preventable cause is interference, either by another patient or by a tactless, overbearing nurse. The prevention of interference by other patients is again, to some extent, a matter of floor-space. There ought to be sufficient room for patients to get away from one another. Avoidance of irritation by the nurses, is, of course, a matter of education and accumulated experience.

Occasionally, however, a patient reacts violently to a *supposed* insult or to an offensive remark heard in hallucination. Violence under such circumstances cannot be prevented, and patients who are liable to these outbursts must be placed in a ward where there are plenty of nurses to control them. Sometimes violence appears to be the result of an accumulation of

pent-up motor excitement. This occurs especially in cases of epilepsy. Epileptics are notoriously violent and dangerous patients. Usually the violence is a premonitory symptom of a convulsion, but in some cases it follows the fit.

Lastly, there are patients who are violent merely out of a pure spirit of rebellion, their idea perhaps being that they may succeed in obtaining their discharge if they can make their presence in the asylum sufficiently objectionable.

The late Sir Thomas Clouston used to speak of dangerous suicidal patients who wished to commit murder in order that they themselves might be killed or hanged. These must be very rare; I have never come across such a case. Obviously such would be extremely dangerous patients.

There is, of course, no end to the delusions which may incite to violence. I remember a patient, for example, who had the delusion that he was God Almighty. He was, however, not satisfied that his muscles were strong enough or his lungs capacious enough for such an exalted position. Accordingly he made a murderous onslaught on his nurse one night, because he wished to gain possession of the nurse's muscles, and he wished to kill me so that he might obtain my lungs.

Any given violent patient usually attacks his victim in the same way. One always strikes with the closed fist, another with the open hand, another always kicks; another uses some weapon, such as a broom or a poker, or a stone tied into a handkerchief or into the toe of a sock; another hurls some missile, such as a vase or a billiard-ball. Similarly, the choice of a victim varies with different patients. Most of them are cowards and therefore attack those patients who are unable to defend themselves. Others select the attendants or medical officers. Even the Commissioners have been attacked on a few occasions during a visit to an asylum.

As in the case of ordinary excitement, a cause for an attack of violence can usually be discovered, although the reaction of the patient is admittedly excessive in relation to the provocation. Asylum nurses get to know the particular circumstances which are liable to induce an attack of violence in many of their patients. I know one patient who thinks that he is the Emperor of the Universe, and that the institution is his palace. He is usually a most agreeable person, but he is liable to strike any patient who damages any of the institution property, even in so small a matter as picking a flower. Violence limited to such occasions has a beneficial disciplinary influence among the other patients, and it need hardly be said that little notice is taken of this patient's violence. As a rule, however, violence is a symptom to be dealt with.

In the last chapter I pointed out that excitement is contagious. It might, therefore, be thought that it would be unwise to place a number of violent patients together in the same ward. In practice, however, this principle is found to work extremely well. The aggressive tendency of the other patients has a restraining influence which is advantageous to the general community. Such a ward is commonly known among nurses as the "refractory" ward. I do not like the term; it suggests to potentially refractory patients that aggressiveness is presupposed and that suitable provision for it is made. It is better to refer to the ward as "No. 1" or the "King Charles" ward, whatever it may be. It is true that patients soon get to know the character of the ward, believe it to be much worse than it really is, and look upon it as more or less of a disgrace to be sent there, but there is no objection to all this.

Suppose a patient in such a ward has an attack of violence, what is to be done with him? Certainly he should not be placed in isolation in a padded or single room unless other circumstances necessitate this course. Personally, I am in favour of turning him into the

garden by himself and keeping him there till his aggressiveness has blown over. Here again there is no harm if the patient considers himself in disgrace. Confinement in a single room, however, only makes him worse.

Just a few words on the mode of dealing with a violent patient. As every asylum nurse knows, no bruise is tolerated by the authorities, no matter what the provocation may have been, and any sign of such a thing leads to an inquiry. How, then, are we to deal with a violent patient ?

The one essential rule is never to deal with him single-handed, but to obtain assistance. Every nurse in an institution for the insane is provided with a whistle attached to his bunch of keys and it is intended to be used under just such conditions as we are now discussing. Do not shout "Help!" or "Murder!". Such a cry might and probably would be mistaken for a false alarm by some patient. Blow your whistle. Of course, if there is another nurse within easy earshot, who knows your voice, you would naturally call to him for assistance.

I suppose it need hardly be said that every nurse, who hears a call or whistle for assistance and is not engaged in the supervision of suicidal patients, should respond at once, without a moment's delay. No matter whether he be off duty or even in bed, the summons is urgent and must be obeyed. This applies to medical officers as well as to nurses. It is important that somebody should be on the spot as soon as possible to avert calamity, and nobody can tell who has the greatest chance of being there first. A violent patient must be overcome by weight of numbers and never by blows or any such form of retaliation. It is not considered clever in an asylum to overpower a patient by oneself. On the contrary, it is regarded as bad form—as bad as refusing to pass the ball on the football field.

Nevertheless, it is obvious that occasions must arise when a nurse is left for a time to deal with the situation single-handed. It does not occur often, because nurses

get to recognise forewarnings of violence in patients—loquacity in one, refusal to dress in another, a sleepless night in a third, pallor of the face in a fourth and so on. But what is to be done if the nurse is taken completely by surprise? This depends on the mode of attack. A blow can either be received on the arm or avoided by keeping one's distance. A kicker is overthrown by catching and holding the kicking foot. If the patient has a weapon, the nurse should run in and seize the patient round the waist, with or without the preliminary use of a chair to receive the blow. If the patient runs in, the nurse should keep the patient on his (the nurse's) right, place his right foot behind the patient's right foot and quickly push him backwards, seizing his clothing in front and gently letting him down on the floor.

Weapons are, or should be, inaccessible to patients. Brooms and brushes are locked in a cupboard; pokers are locked in the coal-box, etc.

It must be understood that a separate chapter has been devoted to violence, not an account of its frequency, but on account of its importance when it does arise.

## CHAPTER VIII.

### DEPRESSED PATIENTS.

IN any hospital for patients suffering from acute mental disorder and among the recent admissions to any of our large asylums it is found that by far the greater number of the patients are depressed. Not recognising that they themselves are insane, they are liable and anxious to ascribe their depression to their being placed among "a lot of lunatics"; but the fact is that they have been brought there because at home they were in a state of misery which was not warranted by the circumstances in which they were placed. The friends of the patient frequently believe that there is some justification for this complaint, and ask whether the association with other patients is not likely to have a deleterious influence. My usual answer to such an inquiry is to explain that nearly half the patients recover under these very conditions and that the remainder are suffering from an incurable form of disease.

Pathological depression may occur at any period of life and practically in any variety of mental disease. The usual cause is melancholia occurring during senility or pre-senility, or as a part of maniacal-depressive insanity; but depression may be symptomatic of dementia præcox, epilepsy, general paralysis, neurasthenia, certain delusional states and a variety of other mental disorders.

From a nursing point of view depressed patients may be divided into cases of simple depression, restless or agitated cases, stuporous cases and delusional cases.

By simple depression is meant a state in which the patient feels depressed and realises that there is something wrong with him, that his condition is really an illness. The agitated cases are those in which the depression is accompanied by a certain amount of motor restlessness, the patient pacing up and down the room like a caged animal, picking his nails, fingers or face, to such an extent sometimes as to cause permanent scars ; plucking at his beard or fumbling with his buttons or other parts of his dress ; groaning, moaning or giving expressions to such utterances as " Oh dear ! " " How awful ! " etc. The stuporous cases, are, as it were, paralysed by their sense of fear or misery ; they stand silent and motionless in a fixed attitude in which the limbs are rigidly fixed, the arms being usually flexed and held to the side and the head bowed down. The delusional cases are those who ascribe their misery to some fancied state of affairs which, if it were true, would often be sufficient to justify their depression. They believe that they have committed " the unpardonable sin " and are doomed to eternal damnation, deserted by God, and so forth ; that they are going to lose their reason and can never recover ; that they are diseased, rotten and putrifying ; that their bowels are obstructed ; that they are ruined financially and destined to beg in the gutter for food, or that their children are being killed. Such notions are quite commonly an exaggeration of real situations or incidents. In one patient, for example, the unpardonable sin turned out to be that he had on one occasion used two penny stamps which were really the property of his employer.

Now there is a regrettably prevalent idea that the proper treatment of all such patients is to " rouse " them out of their depression, to upbraid them for not keeping themselves busy, or to tire them out by marching them round and round a garden. The practical outcome of treatment of this kind is either to make the patient worse or at least to retard recovery, and those who adopt such measures fail to realise fully that the

patient is suffering from an illness. Occupation is, of course, beneficial to chronic patients, but not to those who are acutely ill.

The most satisfactory and efficient treatment for these cases is quite the reverse, viz., rest in bed. The patient should be put to bed and kept there till all signs of restlessness have passed away and he has acquired a habit of resting quietly. To a nurse unfamiliar with patients of this class this may seem a very simple remedy, relieving him of a great deal of work ; but, as a matter of fact, it is by no means an easy matter to keep a melancholiac lying in bed, for it will be found that he generally either sits up in bed or stands by the side of it, and a nurse who has half a dozen of these patients to keep lying down in bed has about as much work as he can do. It has to be done by constant persuasion and cajolery and with the utmost patience. I need hardly say that the patient is not to be held in bed by force ; this would only be met with continual struggling, which could scarcely be regarded as repose. I have no suggestions to offer ; each nurse must be left to his own discretion to achieve his object. This is only one of innumerable instances in which a mental nurse must exercise tact and rely upon his own resources in order to rise to the occasion.

Should any of these patients in bed desire to have something to do in order to distract their minds from painful thoughts, I recommend that they be allowed to knit, especially with long wooden needles. Other salutary occupations are the making of wool rugs and basket-work. For those who have passed the bed stage there should be plenty of games and puzzles to engage their attention, but not such as require much mental effort. Chess, for example, must on no account be allowed, and only those to whom bridge has become automatic should be permitted to play the game. There ought always to be something of interest going on, such as tennis, billiard or bagatelle tournaments, book-teas and so forth. A portion of the ward might be rearranged

so as to give patients an opportunity of airing their views. There might be a dancing class, at which patients who can dance would give instruction to those who cannot. Personal interest in the nurses should be encouraged ; especially, for instance, if one of their number is about to be married.

Depressed patients are usually sufferers from obstinate constipation, and care should be taken to secure a regular action of their bowels. Indeed, agitation is very largely the result of constipation.

In a previous chapter I have already mentioned that every depressed patient is a potential suicide. This fact, which is of the utmost importance, bears repeating, because it should never be absent from the nurse's mind.

Refusal of food is another symptom of frequent occurrence among cases of depression. The symptom is partly mental and partly due to digestive disturbance ; but, whatever may be the cause, many of these patients absolutely loathe the very sight of food. It is obvious that they must be fed ; but I shall say no more about this subject at present, as I intend to devote a special chapter to it.

The skin of depressed patients requires special attention. There appears to be deficient secretion of sweat, Nature's washing medium, and even the sebum is unduly inspissated and dry. The result is that, unless special care be taken, small pellets of sebum are liable to accumulate all over the body, but especially around the alæ nasi and within the concha of the ear. The remedy is hot water and friction. These patients should be bathed rather more frequently than others, and, while lathered with soap, thoroughly rubbed all over, special attention being paid to the parts of the face already specified. Subsequent friction with the towel is also advantageous.

Seborrhœa of the scalp (dandruff) is also a troublesome symptom, not only because of its effects on the patient (baldness, etc.), but also because it is apparently

communicable to others. Let it be said at once that frequent brushing is no remedy. The proper treatment for this condition is frequent washing with spirit soap or, as a simple but more expensive substitute, Packer's pine-tar soap. It is true that dandruff is remarkably frequent in all forms of mental disease, but I mention it here because it appears to be most common among the depressed patients.

## CHAPTER IX.

### DELUSIONS.

DELUSIONS are liable to occur in most forms of insanity.

In melancholia they are naturally of a depressive type and Sir George Savage used to classify them for practical purposes into those of mind, body or estate, following the hint given in the Litany. To these may be added a fourth group, delusions of persecution, which arise in a few cases of melancholia.

Delusions respecting the mind must be taken to include those concerning the soul, which is really the same thing. Melancholiacs look upon the black side of things, and probably their most common delusion is that they are going to lose their reason and can never recover. Another class, remembering some of their past peccadilloes, believe that they have committed "the unpardonable sin", that their soul is therefore lost and that they are deserted by God and doomed to eternal damnation. Delusions relating to the body comprise notions of throat or bowel obstruction, paralysis of the legs and absence of the brain. Estate delusions are, of course, ideas of financial ruin and its consequences. Delusions of persecution in cases of melancholia usually take the form of a belief that their unfortunate condition is due to interference or harm inflicted by someone else by poison, hypnotism or some other unseen agency.

Maniacal patients, on the other hand, tend to develop exalted ideas. They are Messiahs, prophets, priests and kings, great scientists, doctors, or financial magnates, while physically they believe themselves to be not only perfectly healthy, but exceptionally strong and virile.

The delusions of general paralysis are usually of the same order, but rather more absurd. There never existed such an inventive genius ; he is God Himself, nay, higher than God ; he owns continents, the whole world or the universe ; his athletic powers are phenomenal—his long jump is one minute twenty seconds ; he can throw a cricket ball out of sight ; he can run a hundred yards in five minutes (!) ; he has litters of children ; and his urine is Benedictine. Some cases of general paralysis, however, are depressed ; but even then there is often a curious admixture of exaltation with the depression. The patient, being a king, is depressed on account of his weight of responsibility ; or he owes millions to the king.

The delusions of paranoia are erected on a foundation of a tendency on the part of the patient to see hidden meanings in commonplace incidents. As examples : another person blowing his nose is simply using his handkerchief as a cloak for a sneer or smile ; his wife has joined the choir in order to associate with other men ; a lady wears a flower because she is in love with him ; some ragged children are playing together in order to draw his attention to a social grievance ; and a chance remark by a Salvation Army girl tells him that he is a prophet of the Lord. These are the cases which are popularly known as monomania, because their mental faculties, conduct and judgment are perfectly normal, apart from the subject respecting which their particular delusion exists. Paranoia is a purely delusional state, and those paranoiacs who suffer from delusions of persecution are apt at times to be very dangerous. These are the patients I had in mind when I especially recommended nurses to make an endeavour to see the patient's point of view when speaking of delusions in a previous lecture. They are usually regarded as incurable ; but a few patients of this kind have been cured by adopting the method there suggested.

There is a variety of dementia præcox which resembles paranoia so closely that it has been called dementia

paranoides. It differs, however, in that hallucinations play an important part in the disease. From the nurse's point of view it may for the present be regarded as more incurable than paranoia itself.

A delusional state sometimes arises in epilepsy, owing to the obliteration of incidents from the memory as the result of a fit. A patient now in Bethlem had a fit just as he was crossing the Channel from France, with the result that he believes himself to be still somewhere in France, in some kidnapping establishment, in spite of all efforts to convince him to the contrary. Some delusions even take their origin in a dream, which is subsequently believed to be true.

Transitory delusions are apt to occur from time to time during the course of an attack of confusional insanity. They are then of little practical importance; but the nurse will naturally make every endeavour to calm the patient's mind, should they happen to be of a depressing or terrifying nature. In a few cases of this kind the patient, instead of recovering, develops a chronic delusional state as a sequel to the acute insanity.

Now it might seem superfluous to tell nurses that they should not laugh at these patients or tease them on account of their delusions; but, as a matter of fact, many of these fancies have a humorous or ludicrous aspect, and the temptation to laugh, tease and banter is at times extraordinarily strong, and a nurse has to keep a constant guard on himself not to yield to the temptation in the presence of the patient. Of course, there is no objection to his doing so in the retirement of the nurses' room, but in the ward he should try to view the situation from the patient's standpoint, and consider how he would feel if he were suffering from the same delusion and other people regarded it as ludicrous; for it must constantly be remembered that a delusion is no delusion to the patient. What others regard as fanciful is very real and true to him. Similarly with hallucinations: the patient does not *think* he hears voices or sees faces; he *does* hear voices or see faces.

The happy delusions of some forms of incurable dementia need claim little of the nurse's attention ; and with regard to those of general paralysis, he can only hope that the medicinal treatment of the doctor will prove successful in curing the disease, in which case the delusions will vanish with the disease. When, however, the delusions are of a depressive nature—as in melancholia, for example—the nurse should try to counteract them, not by direct contradiction, but by pointing out where the patient “ might be mistaken ”.

Many delusions are but exaggerations of what is really true. In melancholia, for instance, the idea that the throat is obstructed is merely an exaggeration of the fact that the patient has a revulsion from food ; delusions of bowel obstruction are only exaggerated notions of constipation ; delusions of paralysis are but overstatements respecting a very mild paralysis which really exists in this disease ; and the lost-soul idea has some basis in fact, for the patient's will-power, emotions and many of his instincts are in abeyance—those very mental functions which indicate to him that he has a soul. To such patients I always admit that, for the time being, their soul is paralysed, and tell them that it will again become active as they get well. It is true that they are usually disinclined to believe this ; but it is literally true, and the statement of the fact is the proper way to meet the delusion—if it is to be regarded as such.

There are a good many patients who do not resent a certain amount of banter respecting their delusions ; but even with these it is inadvisable to succumb to the temptation, on account of the effect on other patients.

## CHAPTER X.

### EPILEPSY.

BOTH inside and outside of general hospitals and asylums, general and mental nurses have many occasions of witnessing attacks of transitory loss of consciousness. Naturally and quite correctly their first impulse is to send for a doctor; but, since the attack is usually all over before the doctor has had time to arrive, he (or perhaps in these cases it is she) must be prepared to answer a number of questions about the attack in order to aid the doctor in arriving at a diagnosis and deciding on appropriate treatment.

Was it a faint or a fit? In other words, was it of nervous or cardiac origin? If it was a fit or convulsion, was it hysterical or epileptic? What was the exciting cause, if any? The absence of a cause is suggestive of epilepsy, an emotional cause suggests hysteria and such causes as a stuffy room, exposure to heat and prolonged standing may indicate that the attack was a faint—of cardiac origin.

What was the colour of the face? In fainting it is white, in epilepsy bluish, in hysteria—either bluer or redder than usual. Was there any warning? If so, what was it? Before fainting the patient usually complains of feeling faint or ill, while the warning of an epileptic fit, when such warning occurs, is of an hallucinatory nature—seeing people or things, hearing voices or music, a strange smell, as of something burning, or a curious sensation at the pit of the stomach.

Was the onset sudden or gradual? It is gradual in fainting and sudden in epilepsy, while in hysteria it

may be either. Was there any screaming? A scream or cry at the onset of the attack denotes epilepsy, screaming during the fit indicates hysteria and fainting patients do not scream at all. Did the patient bite his tongue, as often happens in epilepsy, or other people and things, as some hysterical patients do?

Was the chest fixed or moving? Complete absence of all respiratory movements indicates epilepsy, deep respirations suggest hysteria, the breathing is merely shallow during a faint.

What was the position of the thumbs? They are grasped by the fingers in most cases of epilepsy, sometimes they are flexed round the first joint of the index finger; in hysteria they are usually wound round the first two fingers, as in making a fist; in fainting the hands are not clasped at all.

Did the patient talk during the attack? If so, it was probably hysterical. Did he pass water or fæces? If so, it was epileptic. Was restraint necessary? If so, was it to prevent accident, as in fainting or epilepsy, or to prevent violence, as in hysteria?

How long did the attack last? An epileptic fit lasts about twenty to thirty seconds; a fainting attack lasts one or two minutes; an hysterical fit lasts from ten minutes up to an hour or more.

What symptoms occurred after the fit was over? None occur after an hysterical or fainting fit, except perhaps a slight headache; but, after an epileptic fit, the patient either sleeps for a quarter of an hour or so or he performs some strange actions unconsciously (post-epileptic automatism).

If there was a definite convulsion, in what order did it occur? Did the patient suddenly become convulsed all over, as in true epilepsy, or did the spasm start locally, say in one thumb or in one foot or in the face, and gradually spread from there to other parts of the body, as in an epileptiform or Jacksonian convulsion due to some irritation in the brain (tumour or abscess, for example)?

Was consciousness lost? If so, at what stage? It is lost at the very beginning of an epileptic fit.

There are two varieties of epileptic fit. One, which is known as a major fit or *grand mal*, is characterised by a convulsion affecting the whole body and by loss of consciousness lasting about a minute. The other, minor epilepsy or *petit mal* is a momentary loss of consciousness, two seconds or less, unattended by convulsion or spasm of any kind. The patient may possibly drop something he holds in his hand and there may be a slight change of colour, the face becoming a little blue. Otherwise, there is nothing to indicate that the patient has had a fit. Indeed minor epileptic fits are very liable to pass unnoticed. Asylum nurses usually call them "sensations". It is generally held that these minor fits, which are usually more frequent than the major variety, have a more deteriorating effect on the mind than the generalised convulsions.

I must not leave these physical aspects of epilepsy without reference to the *status epilepticus* (epileptic state). This is a condition in which the patient has a large number of fits within a short space of time without recovery of consciousness between one fit and the next. As many as one hundred in a few hours are not at all uncommon and on several occasions I have known more than two hundred and fifty in the course of a single day. Some patients invariably have their fits in batches like this; but the condition is always to be regarded as serious. There is a considerable rise of the patient's temperature, sometimes to as much as 105° or more and many cases prove fatal.

Any epileptic is liable to develop status epilepticus, and minor and major epilepsy may both occur in the same patient; but there are many who have either major or minor fits only. At the time of writing, I have a patient under my care who has had hundreds of minor fits daily for many years; but he has never had a major fit.

It will have been remarked that the nurse has a very

large number of observations to make respecting the first convulsion observed in any given patient ; but it is not necessary to repeat these observations every time a convulsion occurs, for it will be found that every fit in any epileptic is an exact replica of his former ones.

The nurse should, however, keep a careful record of the number of fits, so that the medical attendant may be able to gauge the effect of his medicine in reducing them. Not that this is the only aim in the treatment of this disease, for it is now known that epilepsy is due to a poison in the blood and that the fits are an attempt to eliminate it. It is better, therefore, to let some patients have their fits. It is, however, for the doctor to decide which patients should have their fits arrested, and which should be allowed to suffer from periodic convulsions. In the meantime, the nurse should keep a record of the fits.

I have just said that each fit in any given patient is an exact replica of his previous fits. The important practical point of this observation is that each patient has his own particular way of falling when seized with a fit in the standing posture. The result is that one patient always pitches on his forehead, another always strikes his chin on the floor, another falls on one cheek-bone (always the same one), and another always hurts his elbow ; epileptics always fall forward. If, then, the fits are at all frequent, it follows that the point of impact is constantly bruised and tumefied. The nurse should therefore use his ingenuity in devising some way of keeping the threatened part thickly padded. In some cases, of course, the frequency of the fits may necessitate confinement to bed until the number has been considerably reduced by medical treatment. Also, if the nurse knows his patients so well that he can foresee an approaching convulsion, he will naturally put the patient to bed until it is over. What should a nurse do when a seizure occurs ? He should

(1) Turn the patient on his back or side,

(2) Loosen the clothing, especially about the neck, and

(3) Depress the tongue with a tongue depressor or the handle of a spoon, inserted between the teeth, to prevent the tongue from being bitten. There is no necessity to try to force the instrument into the mouth during the initial tonic stage when the teeth are slightly clenched ; it suffices to wait for the first relaxation of the clonic stage, when it can be slipped in easily, for it is during the clonic spasms that the tongue is liable to be bitten.

For the sake of young inexperienced nurses who may happen to read these lectures, I hope I may be pardoned for saying " Don't dash water in the patient's face ! " and " Don't give him brandy ! "

It is estimated that one person in every five hundred is an epileptic and I suppose that about one-fifth of these are to be found in the asylums of the country.

An epileptic convulsion may or may not be preceded by a warning or *aura*, as it is called, and—in my experience—an *aura*, of an hallucinatory character, such as was mentioned in the last lecture, is less frequent in insane than in sane epileptics. When a warning occurs in an insane epileptic, it usually takes the form of a definite attack of insanity, to be described presently. :

With or without a warning or *aura* and with or without, usually without, an initial scream or cry, the patient falls forward unconscious. Immediately every muscle of the body is in a state of strong contraction. His face is distorted, his eyelids, teeth and hands clenched, the latter with the thumbs inside, the arms partially flexed, the legs extended and the chest immobile. This is the *tonic* stage, which lasts about twenty to forty seconds. Then comes the *clonic* stage. Suddenly, all the muscles relax momentarily and contract again, another relaxation and another, the relaxations becoming gradually longer and longer and the spasmodic contractions shorter and shorter until relaxation wins and the patient falls

asleep. The convulsive stage lasts about twenty to forty seconds and the sleep about a quarter of an hour. This sleep is very profound, so much so that—should the patient turn on his face, as he often does—he is liable to be suffocated by the pillow. The sense of suffocation is insufficient to arouse him from so deep a sleep. On account of this feature, some institutions provide special pillows, made of reeds, for epileptics. I am not much in favour of them, because they discount the importance of continual supervision and invigilation.

No attempt to rouse the patient from this post-epileptic sleep should be made, or the patient will suffer from a severe headache. On the contrary, he should be encouraged to prolong his sleep. Even a spontaneous premature awakening is sure to be followed by headache.

In some patients the attack is followed by unconscious automatic actions; but these usually occur after attacks of *petit mal*. They undress, attack bystanders, or continue what they were doing before the fit, to all appearance as if they were fully awake; yet they remember none of these acts when consciousness returns. One man drove a waggon right across London in this state and then found himself six miles from the place where he was, as it seemed to him, a moment before.

#### MENTAL PHENOMENA OF EPILEPSY.

Now any of these states, the aura, the fit itself or the post-epileptic state may be replaced by a veritable attack of mental disorder, and this may take the form of any of the following varieties. The one feature common to them all is that the patient has no recollection of them after he has returned to full consciousness. This is the rule, but there are occasional exceptions.

*Epileptic ill-humour* is a state of depression in which the patient regards his environment as hostile towards him. He is irritable and quarrelsome, makes unfounded accusations against his nurses and fellow-patients, and complains about the quality of his food or medicine.

Often he proclaims that he is suffering from a host of physical discomforts, such as headache, abdominal pain, constipation, etc. ; but these are quite commonly non-existent and simply invented to attract sympathy. Such patients may be suicidal and should therefore be under constant supervision.

*Epileptic excitement* is of such intensity and severity as to have earned the name "epileptic furor". The general aspect of the patient is repellent, his face livid, the eyes staring and the expression that of anger. He is impulsive and violent, makes wild rushes at bystanders or struggles violently. In a few cases, however, the excitement is of a happier type.

*Epileptic confusion* is a state in which the patient loses his memory and is incapable of taking in the nature of his surroundings. He does not know where he is and cannot understand what is said to him. His movements, too, appear to be aimless and purposeless.

*Epileptic delirium* is characterised by the existence of numerous terrifying visual hallucinations—fearsome animals, ugly faces, devils, fire, etc. These naturally dominate conduct, and the sufferers pay little heed to what is said to them. It is therefore difficult to examine them ; but there appears to be a certain amount of mental confusion with loss of memory and inability to comprehend their true surroundings. Some such patients see God and the angels in their delirium and consequently adopt an attitude of prayer.

*Epileptic stupor* is a condition in which the patient stands rigid, motionless, speechless and silent. Occasionally there is an impulsive detached meaningless utterance or he may impulsively strike a passer-by. There is a good deal of mental confusion, the patients probably do not understand what is said to them, they are dirty in their habits, and they usually refuse food or else take it in a purely mechanical way.

Every patient, who exhibits such psychical manifestations as a forerunner or equivalent of or sequel to his fits, has the same variety of mental disorder every time. He does not show ill-humour on one occasion and delirium on another.

Some epileptics are fortunate enough to have only half-a-dozen fits in the course of a long life, but the majority have their fits at least once a month. The ultimate result of this, especially in cases where there is much periodical mental disturbance, is gradually increasing and ultimately profound dementia. The old epileptics of an asylum lead a useless life and purely vegetative existence. They sit huddled up in corners, do not associate with others, and are wet and dirty in their habits. The nursing consists of looking after them as one would look after a child of six to twelve months of age, and their dirty habits necessitate frequent attention to prevent the formation of so-called "bed-sores".

Epileptics have their peculiarities, not only between their convulsive attacks, but even before they have ever had a fit. They have a monotonous voice and periodical attacks of emotional instability; even as children they are subject to uncontrollable fits of passion. They tend to be hypochondriacal, they are egotistic and selfish, and always on the look-out for sympathy; but they exhibit, as a rule, no sympathy for others. On the contrary, they try to get others into trouble. They make false accusations of ill-treatment against the nurses, and show self-inflicted bruises to corroborate their statements. Their conduct is violent and brutal and their reaction to opposition (real or imaginary) is disproportionately savage.

In ludicrous contrast (perhaps as a cloak) to their inhuman instincts, they are strikingly religious. They pray in public, sing hymns at the top of their voice and read the Bible daily. They are typical Pharisees.

The care of epileptics is the most trying part in the career of a mental nurse. Most nurses can put up with a good deal of hostility and aggressiveness from a

patient if they can hopefully look forward to his recovery or amelioration as the result of their efforts ; but, up to the present, epilepsy must unfortunately be regarded as an incurable disease. He is a born mental nurse, therefore, who can successfully tend and manage the epileptic insane with the tenderness, compassion and sympathy which, after all, is their due. The symptoms, which I have endeavoured to expound, are their misfortune, not their fault.

## CHAPTER XI.

### GENERAL PARALYSIS.

GENERAL paralysis is a disease of the brain due to invasion of the body by the micro-organism of syphilis or, at least, by a micro-organism closely allied to that of syphilis. Post-mortem it has been found in the brain of a number of patients who have died from the disease, and it is probable that it is always there, although not always found, because this is an extremely difficult matter. Nevertheless, general paralysis is not contagious ; no nurse has ever caught the disease from a patient, nor has any pathologist, although many such gentlemen have been engaged in handling general paralytic brains for many years.

General paralysis is an organic disease, by which is meant that definite visible changes take place in the brain as the result of certain chronic inflammatory and degenerative processes. It has hitherto been regarded as having an invariably fatal termination within a few years, two to three as a rule ; but the results of various forms of medical treatment, recently inaugurated, have been rather encouraging, and I have reason to believe that some cases have been cured. About twenty per cent. of the cases have remissions, that is to say that they get well enough to go about their business for a few months and then relapse ; but I am not referring to these when I speak of cures.

Twelve to thirteen hundred patients die of general paralysis every year in England and Wales alone. About four-fifths of these are males and one-fifth females. They are usually between thirty and forty

years of age ; but the disease may occur at any age between the limits of seven and sixty-five.

The initial stages, which are seldom seen by the nurse, are marked by restlessness, insomnia, incapacity of attention to business and loss of memory for future events. Yes ! for *future* events. They can answer to the ordinary memory tests for past events quite well, but they forget appointments, they forget that they have to catch a train (in the future), they forget to lock the safe, and so forth. In money matters also they forget to look to the *future* and they spend money recklessly, order half-a-dozen watches, a grand piano and a couple of motor-cars, none of which they can afford. In this stage, too, they are liable to commit indecencies. Usually it is not until the occurrence of some such preposterous conduct that the relatives realise that the patient is insane.

Similar symptoms occur in other forms of mental disorder, but general paralysis is characterised by a number of distinctive physical signs, most of them rather ill-marked at first, but becoming more pronounced as the disease advances. These are loss of the pupillary reaction to light, alterations in the knee-jerks, tremors—especially of the tongue and facial muscles, difficulty and ultimate blurring of the articulation, loss of facial expression and a shuffling gait.

In the classical variety of general paralysis, the patient next develops delusions of grandeur, some examples of which were given in the chapter on delusions. Hallucinations occur in about a quarter of the cases. The patient's mind is full of impossible schemes for accumulating wealth and improving the world. He collects rubbish and fills his pockets with it in the belief that it possesses extraordinary value. He is excited, feels well, strong and virile, and breaks or tears the asylum property to show his power.

During this stage he is liable to attacks of convulsions ; but these may occur at any time. There are several varieties. The commonest is just like an ordinary

epileptic fit ; I have even seen attacks like *petit mal*, followed by automatic acts. Jacksonian fits occur, followed by paralysis. Paralysis of the limbs sometimes occurs without previous convulsion and the temperature rises for a couple of days, apparently without cause, but really as the result of some similar change in the brain.

The patient's appetite is extraordinarily good during this period and his sleep is excessive, so that he usually puts on considerable weight. This state of general paralysis has accordingly merited the name of the " fat, fatuous and fitty " stage.

The disease and the accompanying weakness progress until, finally, the patient becomes bedridden ; yet, up to the last, he maintains that he never felt better in his life. There is no disease so satisfactory as this, from the patient's point of view.

The body and limbs become progressively weaker and emaciated, until body and mind are completely paralysed, and the patient is ultimately reduced to the same helpless condition as on the day of his birth, nay, earlier than this, for even the power of swallowing disappears.

His mind is a blank, there is no perception, he knows nothing of what is going on around him, and he has no memory, no emotion, no feeling. He is merely a reflex machine, leading a purely vegetative existence. All excrement is passed under him and there is great liability to the formation of bed-sores. This is the state in which the general paralytic passes away, unless life is cut short in the earlier stages by some intercurrent disease or by status epilepticus.

Not all cases of general paralysis run this classical course. About one-fifth of the patients are depressed, and occasionally we meet with a patient who becomes progressively demented without either exaltation or depression, and without the development of a single delusion.

I have in previous chapters explained the treatment of states of excitement and depression and of delusions,

and the general management of patients will be dealt with in a future chapter ; but there are two special features of general paralysis to which I must here refer.

One of these is a tendency of general paralytics to bolt their food. Even quite early in the disease, before they are placed under special care, they will, for example, attempt to swallow potatoes and slices of meat whole. The result is that they are very liable to choke ; and there is a curious custom, in some old asylums, of keeping a probang in each ward for the purpose of clearing food from the throats of choking patients. But prevention is better than cure and now it is an invariable rule that the food of general paralytics be cut up small. Meat is, in fact, practically always given in the form of mince, and their potatoes are always mashed.

The other troublesome feature is the tendency to the formation of bed-sores during the later stages of the disease. To prevent these, the patient must be examined once every hour to see whether he is wet or dirty. If so, his clothes must be changed and he must be cleansed with warm water and Castile soap. The parts are then sponged over with alum, 10 grains, methylated spirit, one pint, and dusted with powdered oleate of zinc.

Bedridden patients should have the whole of the skin of the limbs and body up to the neck treated in this way once a day. They are best nursed on a water-bed. If not, the sheet should be stretched tight and pinned to the mattress. In any case, care should be taken that there are no crumbs or other foreign substances in the bedding.

Should the skin break, wash the part over with warm water, to which a teaspoonful of Eusol has been added, and Castile soap for about five minutes ; dry carefully with a clean towel and paint the part with Friar's balsam every four hours allowing it to dry each time so as to form gradually an artificial skin, and place the patient on a pneumatic ring. The treatment of more serious bed-sores should be left to the doctor.

## CHAPTER XII.

### DEMENTIA.

OF the patients admitted to an asylum about forty to fifty per cent. recover and are discharged, the number varying to some extent with the proficiency of the nursing. The remaining fifty to sixty per cent. go to swell the permanent population of the institution. Although still suffering from mental disorder of some kind, many of these are capable of quite useful work and are thus an asset to the establishment ; but the mind and brain of many others have become so profoundly diseased that they are no longer of any use in the world, even in the asylum world, and they have to be looked after like so many infants for the rest of their lives, and usually naughty infants at that. These are the *dements* of the asylum. A few of them, it is true, are capable under direction, of performing a certain amount of menial labour, requiring no intellectual capacity, which in many cases would have been degrading work for them before the beginning of their illness.

Their illness has left them mental wrecks and they are now said to be suffering from *dementia*. But there are many patients whose mental faculties have been blunted so slightly by an attack of mental disorder as not to warrant their retention in the asylum. A second attack may leave further deterioration, a third still more and so on. In other words, they are but slightly demented by the first attack, more demented by the second, much demented by the third and so forth. If, therefore, they start at a very high level, they may at first remain capable men although partially demented. A partially

demented Newton or Darwin might be a better man than most of us.

The general effect of partial dementia is a descent in the social scale. I remember a Baptist minister who after successive attacks, became successively the keeper of a chemist's shop, a grocer, a grocer's boy. On his final admission to an asylum he was at first entrusted with messages outside the establishment, then they had to be limited to inside messages, then he acted as porter to carry plates and dishes after meals, then his work was limited to pulling about the garden roller. Finally he was incapable of even this menial work.

The most extreme dementia is presented by a patient in the last stage of general paralysis, as described in the last chapter ; but, as already indicated, there are many milder degrees. It may occur as the final result of epilepsy, alcoholism, the insanities resulting from sepsis and other infections, and insanities caused by organic disease of the brain, such as tumour, abscess, meningitis, etc.

Most of these dementias are mainly a deterioration of the receptive faculties, such as perception, recognition and memory ; but there is a special dementia consisting of deterioration or disorder of the executive mental faculties. This is known as dementia præcox.

These patients have clear perception. They know where they are and all that is going on around them, though they pay no attention to it ; they know the other patients and their nurses, even by name, and their memory is good ; but their conduct is completely disordered. They get into a corner by themselves, never associate with others and rarely speak or even move of their own accord. If placed in an unusual attitude they stay there. They are quite incapable of occupation and stand, apparently taking not the slightest interest in what is going on around them. Commonly they disregard the calls of Nature, and, like dements of the other variety, soil their clothing.

Occasionally they have an impulse to perform some

silly, senseless, meaningless act, sometimes even striking a passer-by. Others have a way of strolling over the same pitch of ground for hours together, as if they had some purpose in doing so, or of repeating the same phrase over and over again for half-an-hour at a time. Hallucinations, usually of hearing, are the rule, and delusions commonly co-exist. In course of time, however, the delusions are forgotten and the patient just lives in a world of his own.

Dements are neither exhilarated nor depressed. One might perhaps say that their lives are happy in a way, living as they do in a kind of Nirvana. "The hollow laugh that speaks the vacant mind", occasionally seen in these patients, has no meaning. I remember telling a dement his father was dead; but his only response was a laugh of this nature.

The nursing of such patients is a thankless task, in that all the labour bestowed upon them has not the slightest chance of ameliorating their condition. Moreover, they are incapable of even feeling gratitude for the nurses' efforts. Yet somebody must look after them. Even in the dark ages, when certain patients suffering from acute insanities were burned at the stake, these patients claimed commiseration.

Their nursing consists of feeding them, clothing them and keeping them clean. If a plate of food is placed before them, they have no instinct to eat it, because it has no meaning for them; every mouthful has to be placed in their mouths by the nurse. They have to be undressed and put to bed and got up and dressed again like children. Similarly, they must be periodically washed and bathed and, with them, cleanliness must be a special consideration.

On account of their dirty habits they should be inspected once every hour to see whether they have soiled themselves. If so, they must have a bath and change of clothing. Otherwise they will develop sores from action of the excrement on the skin. In practice, however, the washing bill is usually kept down by the

nurse getting to know the usual time when the patient's bowels are open and placing him on the w.c. accordingly. Similarly, he is periodically taken to the w.c. to pass water, and there are various stratagems, well known in asylums, for inducing him to do so.

Other peculiarities call for no special treatment, except in the case of a patient being dangerous and liable to strike others impulsively. All the other patients in the ward should be warned that it is not safe to go too near such a patient, especially to interfere with him in any way. It is not a bad arrangement for impulsive patients to wear some distinctive, but not unsightly, badge. The men, for example, might wear a bright red tie and the women a bright red piece of ribbon across their dress or on their wristbands. Otherwise, the duties of the nurse to patients of this class are just to make their lives as happy and comfortable as he can.

## CHAPTER XIII.

### IDIOCY AND IMBECILITY.

IN previous chapters we have considered states of insanity—mental disorders occurring in persons who, during their earlier years, were more or less normal individuals. Idiocy and imbecility, on the other hand, are states of mental defect dating from birth or arising in such early childhood that the patients never develop a normal mind, but remain for ever (mentally) children. Since the passing of the Mental Deficiency Act they have been known as “mental defectives”. The condition has also been called “*amentia*”, in contradistinction from “*dementia*”, considered in the last lecture.

Some authorities state that mental deficiency arises in the offspring of parents belonging to families saturated with insanity. Others, who—in my opinion—have proved their point, maintain that mental deficiency runs in families, quite independently of insanity, and that insanity proper has nothing whatever to do with it. However this may be, the study of mental deficiency is distinct; the patients are housed, treated, educated and nursed in quite separate institutions, and the nursing of idiots, imbeciles and backward children is a specialty in itself.

There are various ways of classifying these patients. One method classifies them according to their degree of mental development, as compared with normal children of various ages. To say that a given patient is of “mentality 4” means that he has the mental capacity and power of a normal child of four years of age; to say that he is of “mentality 9” means that he is mentally a child of nine, and so forth. Patients of mentalities

1 and 2 are called "idiots", those of mentalities 3 to 7 are known as "imbeciles", and those of mentalities 7 to 12 are called "morons" or, in earlier years, "backward children."

Other attempts to classify these patients are based on the cause of the mental deficiency, so far as it can be ascertained, or on some associated character.

*Genetous idiots* (or imbeciles or morons) are those in whom the disease process in the brain occurred before birth. *Mongolian idiots* are so named on account of their facial resemblance to normal members of the Mongolian races. *Epileptic idiocy* is due to epilepsy beginning in early life. *Cretinism* is due to defective secretion of the thyroid gland, which is unduly small in children so affected; it is treated and often cured by the administration of thyroid gland obtained from animals. *Paralytic idiocy* is associated with paralysis caused by injury to the brain at birth, usually hæmorrhage or thrombosis. *Inflammatory idiocy* is ascribed to chronic inflammation of the brain, occurring as a sequel to one of the specific fevers. *Idiocy by deprivation* is due to concurrent blindness and deafness, the patient being thus deprived of the chief senses by means of which he may learn. *Microcephalic idiocy* is due to smallness and insufficient growth of the brain. *Hydrocephalic idiocy* is caused by the brain being distended with water (cerebro-spinal fluid). This is not a complete list, but it includes most cases.

A special variety of idiocy used to be ascribed to syphilis; but it has recently been discovered that about fifty per cent. of mental deficiency is probably due to this cause. It seems, however, improbable that the discovery will lead to much in the way of amelioration.

Deformities of various kinds are extremely common among the mentally defective. Such are ill-shapen ears, squints, cleft or otherwise malformed palates, odd folds and tags of skin about the face and neck, deformed limbs and supernumerary fingers and toes. Some of these may be remedied by surgical treatment; but

usually it becomes the duty of the nurse merely to conceal deformities by getting the clothing cut in such a way as to do so.

Another point about the clothing is that it should be more abundant than for normal people, because most of these patients, especially the Mongols, are excessively sensitive to cold.

The diet, too, should be very liberal, nourishing and attractive and supplemented by such substances as cod liver oil and extract of malt; not only because the general nutrition is defective, but also to combat the abnormal tendency of idiots and imbeciles to develop tuberculosis. The diet should also be of such a nature as to counteract the very obstinate constipation prevalent among such patients. Those who are given to wetting the bed should be denied fluid for a couple of hours before retiring.

Some patients of the idiot class appear to have a certain amount of difficulty in swallowing and they have to be spoon-fed. Shirking of this duty is apt to lead to choking, which may be serious.

Further to resist the tendency to tuberculosis, special attention must be paid to ventilation of the living and sleeping apartments, by night as well as by day. If they are sunny, so much the better; but, in any case, the patients should spend a large part of their time in the open air.

Idiots have to be tended like normal children of one or two years of age, although their actual age may be twenty, thirty or more. In the adult periods of their existence, perhaps it is better to say that the treatment resembles that of dementia. Their wet and dirty habits, for example, call for exactly the same care.

The treatment of imbeciles and morons consists mainly of a very special kind of education. The education of these children is difficult and has therefore been most thoroughly studied by those who have to deal with such patients. Their study has been so successful that their methods are now being copied by many of

those engaged in the education of normal children (the Montessori system); but it should never be attempted by persons who have not received a special training in such work.

The mentally deficient are remarkably emotional. As a rule, they are very affectionate and they feel punishment acutely; they are therefore easily managed. Many, however, have perverted instincts and like to indulge their destructive and predatory impulses. In fact, there is a recognised variety of mental deficiency known as "moral imbecility", in which the moral far exceeds the intellectual defect.

The first stage in the education of the mentally defective consists of an abundant supply of toys to train manipulative movements. The next stage is the training of interest and attention by selected games. This is very important, for one of the chief difficulties in the education of the feeble-minded is lack of attention. Then comes a kindergarten stage with a multitude of special apparatus for the training of visual, tactile and auditory perception. There are also special methods of training movement and speech, which need not be detailed here; but it is obvious that they must precede class and industrial teaching. Of these, the latter is by far the more important, not only because we can never hope to create a genius out of such patients or because purely academic knowledge cannot be of much use to them, while the learning of a trade may be of practical service; but also because the feeble-minded acquire general knowledge with their hands so much more readily than with their heads.

Even more important than all this, is the moral training, for mental progress without moral improvement will only increase the capacity for evil. In this connection some system of rewards and punishment is essential and the nurse should adhere very strictly to whatever system is adopted. Suitable rewards must never be forgotten and punishments must always be carried out, but mitigated as much as possible so as to

retain affection and confidence. Flagrant crime should always be reported to a higher authority and dealt with severely.

In the moral training of the mentally defective the nurse has an exceedingly responsible duty to perform. He is in constant contact with his patients, knows all their faults and failings, and it is for him, and for nobody else, to correct them.

## CHAPTER XIV.

### FOOD AND FEEDING.

INASMUCH as defective bodily nutrition is very frequently associated with mental disorder, the feeding of the insane is of paramount importance. In acute cases one of the chief endeavours of the nurse should be to increase the weight of her patients, perhaps with the exception of fat alcoholics, and care should be taken that the chronic patients do not lose weight. It is false economy on the part of the authorities of many county asylums to keep down the maintenance rate by economising food.

In these institutions many of the working patients, who are but partially demented, have the run of the place and plenty of access to food, especially those who work in the kitchen and stores departments. As a rule, they therefore look after themselves fairly well; but there is one point to which nurses should pay attention with regard to these cases. Here and there some patient, who is left pretty much to go his own way and whose case does not call for special observation, eats plenty of bread, butter, cheese, meat, etc., but never touches fruit or vegetables. If this is allowed to go on, it is found some day that he has developed scurvy, a disease caused by absence of vegetable food from the diet. The remedy, or rather the means of prevention, is obvious.

The diet of epileptics calls for special mention because it has been found that the number of fits is greatly reduced by allowing no meat. For these patients breakfast consists of bread, butter, marmalade and tea—of course, with milk and sugar; dinner comprises

vegetables, milk, fruit and custard or a milk pudding ; tea is much the same as breakfast, jam being substituted for marmalade, and supper is made from porridge bread and cheese, boiled onions, and fruit. Meat is allowed by some doctors once a week, say, on Sundays. Sodium bromide is allowed instead of salt, which is sodium chloride ; it is better that it should be measured in accordance with the doctor's prescription, and dusted over the food.

The only other chronic varieties of mental disorder to which I must refer in this connection are dementia and mental deficiency. Many of these patients have to be spoon-fed, not because they definitely refuse food, but because the instinct to take food is lost and a plateful of food has no meaning for them.

I have said that it is essential that acute cases of mental disease should put on weight. Sometimes the ordinary diet is sufficient for this purpose. If it is not, the patient should be induced to supplement his meals with an extra glass of milk (perhaps strengthened by the addition of cream), chocolates or a mash of bananas and cream. A drink of equal parts of stout and milk is very good, or a preparation of chopped suet dissolved in milk by placing in the oven overnight, and flavoured with sugar or salt to taste. The latter should be served very hot.

Some confused patients have to be spoon-fed like the demented cases above mentioned, and for the same reasons ; but a large number definitely refuse to take any food whatever and, if left to themselves, would die of starvation. A few of these the nurse is able to manage by himself ; the patient can be nourished by systematically forcing spoonfuls of food, bread and milk or soup into his mouth.

If this fails, there is no alternative but tube-feeding. No attempt should be made to force food on the patient. by means of a feeding cup, as is so often done, filling his mouth with liquid in the hope that he will be obliged to swallow it. The result of this procedure is too often

that some of the fluid goes " the wrong way " and subsequently causes septic bronchitis, food-pneumonia or abscess of the lung. The feeding cup is merely a convenience for bedridden patients. A patient who actively refuses food must be fed through a nasal or œsophageal tube passed right down into the stomach (about seven-teen inches from the incisor teeth).

To accomplish this without unnecessary roughness there are usually required three nurses and a doctor. The patient is made to lie or, rather, to sit up in bed. One nurse sits behind him on the right and holds his wrists while clasping him round the waist, so that each hand grasps the opposite wrist of the patient. The second nurse sits also behind the patient, but on the left, and holds his head by allowing it to rest on his right shoulder, while the forehead is held by the flat of the hand. The left hand is free further to steady the head, if necessary. The head must not be held by pressure on each side against the ears, as this is likely, especially in a struggling patient, to cause hæmatoma auris, othæmatoma, or " insane ear " (an effusion of blood between the skin and cartilage), the ear becoming at first enormously swollen, and ultimately shrinking into a permanent deformity. The third nurse holds the legs by kneeling astride them and placing one hand on each of the patient's knees, applying pressure when necessary to overcome resistance. On a small table near to where the doctor stands, usually on the right of the bed, are placed an oiled nasal or œsophageal tube with funnel attached and the feed in a jug. If the œsophageal tube is used, a gag is also required. The œsophageal tube should be lubricated with olive oil for at least one foot, and the nasal tube for about fourteen inches.

With regard to the choice between œsophageal and nasal feeding, either method has its advantages and disadvantages. Feeding is quicker with the œsophageal tube ; there is less liability to blockage, and the liquid flows more readily ; but there is risk of injuring the teeth with the gag and of regurgitation of fluid from

the stomach round the tube into the pharynx, and perhaps larynx. These disadvantages are avoided by using the nasal tube ; but the process takes longer, the tube may get blocked and have to be repeatedly withdrawn and passed again, and there is risk of its passing into the mouth or even the lungs instead of into the stomach. Moreover, if this form of artificial feeding has to be continued for many weeks, the nasal tube may cause ulceration of the mucous membrane of the nose. Which of the two methods is the better depends very much on the patient ; but generally the nasal tube seems less brutal.

The feed itself consists of a pint to a pint and a half of milk, *slightly* warmed, with a couple of eggs stirred into it with perhaps an ounce of cream or a tablespoonful of extract of malt. In prolonged cases the juice of half a lemon or orange should be added to one meal in each day so as to avert scurvy, a condition in which small hæmorrhages occur under the skin. Such feeds are given three or four times a day ; monotony does not matter, because the patient does not taste the mixture and there is no necessity to vary the meal with soup, for example, which is much less nourishing, in order to give the patient a change. Similarly, it is quite permissible to add an aperient, a sleeping draught or any other medicine as occasion requires.

Disturbance of digestion is a common symptom, very rarely a cause, of many of the insanities, especially melancholia and acute confusional insanity ; and it occasionally happens that such patients are unable to retain even such simple meals as have just been described. In these cases the food must be peptonised. Its temperature is raised to that of the body (98.4° F.), and a peptonising powder is added. The jug is allowed to stand in a warm place for ten minutes and the preparation is then poured into a saucepan and rapidly boiled. It is then returned to the jug and allowed to cool, when it is ready for the patient. At the end of a week the time of peptonising may be tentatively reduced one

minute a day and, when the patient can retain food which has been peptonised for only three minutes, he can return once more to the ordinary mixture.

Some patients, commonly melancholiacs, invoke the aid of cunning to avoid taking food ; they stealthily give it to the cat or throw it out of the window. The remedies are obvious. I remember one such patient who used to conceal a volume of *Punch* in his clothing whenever he was taken to be weighed.

Some patients suffering from dementia præcox will only eat when they are unobserved. The nurse need raise no objection to this peculiarity, but should place the food in some secluded corner for the patient to find it.

Hypochondriacal paranoiacs are the gourmands of an asylum. They eat enormously to avert the impending death they constantly fear, and the result is that they eat too much. Apart from the fact that they usually get excessively corpulent, however, I have never seen any ill effects from their gormandising.

## CHAPTER XV.

### BATHING AND HYDROTHERAPEUTIC MEASURES.

A CERTAIN farm labourer, on being asked how often he had a bath, replied "Never! My sweat keeps me clean." So it does; but the standard of cleanliness in institutions for the sick in mind or body is higher than this, and it is customary for most patients to have a bath once a week unless such special circumstances as dirty habits call for more frequent bathing. In many establishments the fact that a patient has previously been accustomed to a bath every day is not considered a sufficient reason for the continuation of this practice and the patient is positively denied it. For my part, I consider this quite unnecessary tyranny. Sudden deprivation of a customary daily bath causes extraordinary discomfort and irritation, incomprehensible to a nurse who is unaccustomed to the luxury; and I plead for these patients to be allowed their bath as often as it can conveniently be arranged.

Of course there are patients who have a veritable "washing mania" which ought to be discouraged, and the above remarks do not refer to such cases.

A nurse should always be present when a patient takes a bath and his chief duty, apart from preventing attempts at drowning, is to see that the water is not too hot. As a general rule, the temperature of a bath should be about blood-heat ( $98.4^{\circ}$  F.) or certainly no more than  $105^{\circ}$  F. It is a general rule in asylums that the cold water must be turned on first to avoid scalding; but it ought also to be remembered that hot water is lighter than cold and is liable to float on the top and

therefore to make scalding possible although the proportions of hot and cold water in the bath may be correct. A nurse should therefore see that the water is well stirred before allowing a patient to enter it.

Patients who soil themselves must be bathed every time such an accident occurs. In some asylums there is provided in each bathroom a low kind of sink with a wooden platform whereon a patient can stand to be cleansed ; but if the proceeding is carried out in a bath, there ought to be a special one reserved in each ward for such cases. It is very disgusting to other patients to be obliged to use a bath which is known to be used for the dirty cases, however carefully it may be cleaned.

In any case, the special bath should be thoroughly scrubbed with hot water, in which plenty of soda is dissolved, and Sapolio, Monkey Brand or some such soap. It is also desirable to add some antiseptic in efficient proportion.

Should one of these patients be suffering from diarrhœa, the possibility of asylum dysentery should always be remembered and another bath set aside for him. The temporary inconvenience of using up the bathing accommodation of a ward in this way is as nothing compared with the calamity of having several patients or perhaps the entire ward subsequently infected with this dreadful disease.

#### THE PROLONGED BATH.

Patients suffering from various kinds of motor excitement are frequently treated by prolonged bathing. The temperature of the water is maintained at 97° to 98° F., and the patient lies in it half an hour the first day, one hour the second, two hours the third and so on up to six hours or more. The time is then gradually reduced in the reverse order. Female patients usually wear a chemise or asylum dress while they are in the bath. The process is comforting but rather exhausting and patients undergoing the treatment should therefore receive an extra supply of nourishment in the form of

milk and biscuits between meals. They should also have their skin rubbed with vaseline each day before entering the bath, especially that of the hands and feet.

### THE COLD SHOWER

is sometimes given daily to patients suffering from states of stupor, so as to overcome certain resistances in the nervous system. The shower lasts thirty seconds to one minute; but the author considers an ordinary cold bath more effectual. The patient should, of course be under continual supervision during the operation and well rubbed with a rough towel afterwards, so as to promote the circulation.

### THE WET PACK

has rather gone out of fashion, since the Commissioners discouraged its use many years ago because the patients in some asylums were made to regard it as a punitive measure; but those physicians who had most experience of the treatment regarded it as beneficial. The bed is covered with a large waterproof sheet then with a blanket and lastly with an ordinary sheet slightly wrung out of cold water. The patient is laid on this and it is quickly wrapped round him, then the blanket and waterproof, and a couple of blankets are laid over the whole. He remains in this kind of general fomentation for about half an hour, is subsequently sponged with cold water, dried with warm towels and put to bed. The treatment is said to be soothing, to subdue motor excitement, to induce a refreshing sleep and to increase the amount of urine. It is also said to have a slight aperient action.

### ELECTRIC BATHS.

Various kinds are sometimes given to mental patients. An ordinary bath of warm water is prepared, in each end of which is a large flat copper electrode covered with bath towelling. The bath itself must not be made of metal, but of earthenware or wood and the patient must be comfortably settled in it before the electricity is

turned on. Similarly, the current must be slowly turned off before he gets out of the bath or he may get rather a severe shock.

The electrodes are connected by insulated wires with opposite poles of the battery or whatever apparatus is used. A good deal of the electricity is lost in the water, so that patients can usually stand a fairly strong current. The forms of electricity in most common use for treatment are the faradic current for its stimulating effect, especially in stuporose cases, and the sinusoidal current (galvanic current varying in strength with regular periodicity by a mechanical arrangement) to promote the excretion of certain toxic products from the body. I have found this latter form of especial benefit in some cases of dementia præcox.

Many other varieties of bath have been tried in the treatment of mental disorders, including Turkish and Russian baths; but they have all dropped out of use because they have not been found to be efficacious.

The one word I have to say in conclusion is "supervision". Whether a patient is in a bath for purpose of cleansing or treatment or in a "wet pack", he should never be left. Even the prolonged bath demands the constant invigilation of a nurse, however quiet the patient and however tedious the watch.

## CHAPTER XVI.

### URGENCIES.

IN most establishments for the insane new patients are seen at once, on their admission, by the matron or head attendant and examined by one of the medical officers. Where this is not the practice it is an urgent matter to report the admission to the superintendent, together with any information obtained from those who brought the patient and observations made after he has been received into the ward.

The first duty of the head attendant is to search him, to abstract all valuables and to return them to the friends, obtaining a receipt, to take away all cutting or otherwise dangerous implements, even a handkerchief if the patient is said to be suicidal, to remove all clothing and to give him a bath if he is not too ill. This gives the nurse an opportunity of noting any physical peculiarities such as a rupture, skin eruptions, bruises or especially among female patients, a dirty head infested with nits. The temperature should be taken, if possible, and inquiries made respecting the taking of food, the passing of urine, menstruation and evacuation of the bowels. A few mental peculiarities will be noticed at the same time and a complete report submitted to the superintendent. The night nurse will make a report respecting the sleep and passage of urine, obtaining a specimen and any action of the bowels ; all of which should be reported in the morning.

Apart from the admission of new patients to asylums, there are many urgent matters demanding the immediate notice of the superintendent. Occasionally these are

of general importance, such as an outbreak of fire, but usually they have reference to some patient.

The sudden unexpected death of a patient, for example, should be reported at once, as also should the occurrence of unusual symptoms, such as acute pain in the abdomen or chest, the spitting of blood or the appearance of blood in the urine or stools. The nurse should be careful to see that no food whatever is given to a patient suffering from abdominal pain until he has been seen and examined by the doctor. The incidence of a fit in a patient who is not known to be an epileptic should also be immediately notified. Skin eruptions are important because they may be symptomatic of an infectious disease.

Other matters which are not quite so urgent, but ought to be reported before the end of the day, are vomiting, diarrhoea, the discovery of a rupture while bathing a patient, the fact that a certain patient has not passed water, and refusal of food.

Prolonged constipation is another matter to be declared ; but the nurse should satisfy himself that the constipation really exists, because many patients suffer from the *delusion* that their bowels are never open. Similarly, some complain of diarrhoea when none exists. In some cases this is a delusion ; in others it is an almost legitimate subterfuge to escape a dose of the unnecessarily powerful purgative usually given.

Discharges, especially foul-smelling discharges, from the vagina must always be reported, and the nurse should examine for them carefully in every new patient who has recently given birth to a child. Early treatment of these cases may be essential to the ultimate recovery of the patient (mentally).

All injuries to patients, such as fractures, cuts and bruises, must be reported at once and details of how they occurred carefully recorded because they lead to official investigation in many cases. "First Aid" should, of course, be applied to fractures in restless patients and to any dangerous hæmorrhage.

An outbreak of violence naturally calls for immediate treatment, if only for the protection of the other patients and the nurses.

The most important urgency of all is a serious attempt at suicide. Naturally, when this occurs, the nurse's first thought will be to send for the doctor ; but this is not necessarily always the first thing to be done. If the patient is found hanging, cut him down ; if drowning take him out of the water and, in either case, start artificial respiration. If he is bleeding furiously from a large vein or artery, staunch the blood by local pressure and so forth. When you are satisfied that a nurse can be spared, and not before, send for the doctor ! These are cases, before all others, in which the nurse will appreciate his "First Aid " training.

I take this opportunity of recommending every asylum nurse to pass the St. John Ambulance "First Aid " examination in his first year of training. When I was superintendent of Bethlem Royal Hospital I made this compulsory among my nurses.

In every asylum it is the rule to count the knives, forks, etc., before and after each meal, and let me now say, while on the subject of suicide, that the discovery that a knife or fork is missing should be reported at once. Similarly, the disappearance of a pair of scissors, a bottle of medicine or, when there are workmen in the ward, of a chisel, saw or other cutting instrument should be published at once. A systematic search will naturally follow.

Another general rule in asylums is to count the patients in and out when they go to work or, say, into the garden or dining hall. If one should happen to be missing the nurse will, of course, find out who it is and report the matter. It does not necessarily follow that the case is an escape. If the patient is still in the asylum grounds, it is not an escape. Even if a patient runs away outside the grounds, it is not an escape unless the person in charge loses sight of him. Of course, the result of a report that a patient is missing is that

a search is instituted and, in most cases, he is soon found.

Lastly, but by no means least in importance, let me remind my readers that there are other people in their establishment than the patients. It occasionally happens that a nurse falls ill. He is surely entitled to as much consideration as the patients and such illness should be reported. How often have I gone through a ward and seen all the patients without my attention having been drawn to a sick nurse! I suppose that bashfulness is at the root of the matter; but let me assure nurses that every medical man is anxious for their welfare and is glad to take any amount of trouble in restoring them to health, should necessity arise. Whenever it is observed or otherwise known that there is anything the matter with one of the nurses, the matter is urgent and the doctor's attention should be called to it. This is more especially the case with a nurse on night duty, not only because night work is very arduous for a person who is suffering even from a slight ailment, but also because the night nurses are liable to escape the personal observation of the doctor.

## CHAPTER XVII.

### CLEANLINESS, ORDER, ETC.

ONE of the duties of a mental nurse is to teach his patients to be clean and tidy. "Example is better than precept" and he should set an example in his own person. The outer garments of a male nurse do not naturally present the spotless appearance of the laundered apron and cuffs of his sister colleagues and he is therefore obliged to be more scrupulous in the care of his clothes. They must be brushed every day and he should keep a bottle of ammonia in the ward to remove grease spots from his own clothing as well as from that of his patients. Soap and water and a nail brush are even better, but an especially recalcitrant spot can often be effaced with chloroform, a small bottle of which he might keep, under lock and key, in his room by a friendly arrangement with the dispenser.

The outer garments, however, are not everything. A nurse should be clean from the skin outwards and his bedroom should be an attractive boudoir with never a speck of dust. It is surprising how cleanliness of this order will command respect and gain the best friends in the institution. It is also surprising how colleagues and patients know intuitively and unconsciously when a nurse's clean and smart appearance is all on the surface.

The ward is the nurse's next consideration. It must always be spotlessly clean without a speck of dust to be found on the furniture or elsewhere. The female side usually beats the male in this feature. Visitors to the wards frequently remark on this point. On the female side they say "How clean everything is!"; on the male side "It is not so nice as the other side." Surely

this need not be. The beds should present a clean appearance, no stained sheets or pillow-cases being permitted, and they should be tidy during the day. A dormitory looks particularly neat and orderly if all the beds are made up in exactly the same way, the ends of the upper sheets being all in the same straight line, even including those of beds on the floor. Male nurses, as a rule, make beds better than female nurses; they are usually more particular, for example, in seeing that the undersheet is stretched tight and they observe the above-mentioned points more scrupulously.

The store cupboards should be arranged in a systematic and orderly fashion, so that the nurse can at any time lay his hand instantly on any article he requires. The same remark applies to the medicine cupboard; remedies for outward application being placed on a different shelf from that for medicines for internal administration or, better still, in a separate cupboard. Lavatories must be kept clean and well aired. Basins must be kept empty and clean and a good nurse will insist on the soap, nailbrushes and sponges being always in the same place.

As most mental patients are rather inactive, I think that the temperature of a ward should not be less than 60° F. Fires should be kept burning brightly in winter, but not piled up to such an extent as to waste the coal. Dressing-rooms should be warmed before being used. Old people, demented and stuporose patients are very susceptible to cold and they should therefore wear flannel underclothing. Patients who will not remain in bed must wear warm combinations.

In such surroundings there is every inducement for the patients to keep themselves clean and tidy; but many, of course, require supervision. The nurse has to see that they wash the face and neck properly and are not satisfied with wiping the face with a wet corner of the towel. They should wash their hands before meals, especially those whose hands are usually clammy with sweat, as is the case with so many of the insane.

The hair should be neatly dressed. Not every patient on the female side need be compelled to dispense with hairpins; but those who can dress their own hair should be obliged to use hairpins that are not liable to fall out. I understand that the best for this purpose are those with one large curve in the middle of each shank. Patients who are continually taking down their hair must have it tied up with thread, which has to be cut off again every day so that the hair may be well brushed.

Large numbers of the insane suffer from dandruff, but no amount of brushing is of the slightest use for curing this disease. The proper treatment for the condition has been described in a previous chapter. The nurse must keep a sharp look-out for nits; these can be removed after the application of vinegar or, better, spirit of chloroform with a small-tooth comb. The nurse will, of course, see to it that patients never use any other than their own brush and comb. Both the above conditions are infectious and may elude discovery until another patient has been infected. If a really dirty head is found in an asylum, some nurse has failed in her duty.

Every patient should have a toothbrush and the nurse should insist on its being used at least once every day. The nails should be kept cut; those patients who pick holes in their skin having them cut frequently and as short as possible.

Corpulent patients are apt to suffer from chafing of the skin where it hangs in folds, in the armpits and under the breasts. It is not desirable to wash such parts too frequently with soap and water; they should be cleansed with a little sweet oil on a piece of lint, dried and powdered with oxide of zinc. If this be done night and morning, the condition will be cured in less than a week.

The clothing of patients requires supervision. Collars must be buttoned, neckties tied well up to the collar, bootlaces tied, stockings pulled up and all buttons and

other fastenings duly fixed. As soon as it is discovered that a button or hook is missing, it must be sewn on at once.

The clothes are to be kept clean, a proper number of clean collars supplied and all food stains removed from the front dresses or waistcoats. Patients should be made to fold their clothes neatly every night and to brush them before going into the garden next day. And when they come in, nurses should see that outdoor clothing and boots are tidily put away. Patients cannot be expected to do these things spontaneously and the nurses must train them into tidy habits in such matters.

In the arrangement of meals, the nurse should separate those patients who have unpleasant habits from those who behave well at mealtimes. If there is only one table in the dining-room, the well-behaved should be at one end, the badly behaved at the other. Then, as a patient improves in his habits, he may be promoted by gradually moving him up the table among the better patients. Good conduct is thus encouraged and the head of the table becomes the ambition of each patient.

Mental nurses have a great deal of work in the course of the day and they are on this account rather inclined to hurry patients over their meals. This should not be. It is impossible to lay down an absolute time for the duration of a meal, because the number of courses varies in different institutions and, for that matter, in private ; but, just as the velocity of a fleet is that of its slowest vessel, the duration of a meal must be that of the slowest eater.

## CHAPTER XVIII.

### GENERAL MANAGEMENT.

It is in the natural order of things that the patients in any large asylum have extremely varied interests and those in any particular ward have a tendency to form sets or coteries in accordance with their community of interests. There is not the slightest objection to this. Indeed the charge nurse should arrange the furniture of a ward in such a way as to invite the patients to collect in small groups. It is to be regretted that modern asylums built, for economical reasons, on the pavilion system render this much more difficult than the older asylums built on the corridor system ; but the nurse should do his best with the ward at his disposal. If it is found that any particular patient has a detrimental influence on another the matter should be reported with the suggestion that one or the other should be transferred to another ward. Apart from community of interest, it should be possible for patients to avoid association with those who have dirty, irritating or other unpleasant habits.

In wards devoted to the treatment of recent acute cases there should be a sufficiency of couches and easy-chairs to invite the patients to rest as much as possible and it is one of the nurse's duties to encourage patients, suffering from acute mental disorder, to rest for a couple of hours each day. If they can sleep without interfering with their night's sleep, so much the better ; but they should not be allowed to sleep during the day if it is found that this prevents them from sleeping at night.

As every mental nurse knows, insomnia is one of the

chief troubles in acute cases of insanity and, too frequently, sufficient sleep can only be obtained by resorting to hypnotic drugs. The nurse himself, however, can often do a good deal to encourage sleep in his patients and thus avert the necessity for drugs. Sleepless patients should be assigned to a quiet part of the ward, or, at least, to a part where they are out of earshot of screaming cases in other parts of the establishment; and rattling windows should be wedged. There should be a sufficiency of ventilation, the amount approximating to that to which the sleeper is accustomed. If he complains of being cold at night, an extra blanket must be allowed or perhaps a hot-water bottle if he suffers from cold feet. Some, on the other hand, are unable to sleep because they are too hot. In this case one of the coverings ought to be removed.

There is a common notion that a meal taken too shortly before retiring provokes insomnia; but I think that a much more common cause is hunger and that sleep can frequently be induced by a glass of hot milk with a few biscuits. The night nurse must therefore be provided with these necessities, to use at his discretion.

One of the chief duties of a nurse is to attend to the ventilation of his ward. Ideal ventilation is such as will keep the air of the ward as fresh as that in the garden without causing undue draught or lowering the ward temperature too much.

Leaving out of consideration the chimneys as outlets and the cracks of doors and windows as inlets, fresh air is mainly admitted through open windows and ventilators. If the latter are within reach (Tobin's tubes, for example), they require frequent examination because many patients utilise them as receptacles or hiding-places for their treasures. Ventilators quite close to the floor are sometimes regarded by patients, entrusted with the duty of sweeping the ward, as holes into which the dust should be swept, in which case they are rendered worse than useless, because the air of the ward subsequently becomes thoroughly impregnated with dust.

As a general rule, the nurse ventilates his ward by a judicious use of the windows. Those on the leeward side may be opened freely and here and there, where patients do not usually sit, on the windward side also. Meanwhile it should be seen that none of the patients is sitting in a direct draught. Demented and stuporose patients are apt to do so without noticing it, with the result that they get seriously chilled. Draughts should always be across a ward and never along it so that there is no escape. There should always be a cross draught between the w.c. and the general ward.

The practical way of deciding whether a ward is sufficiently ventilated is to note whether it seems stuffy to a person coming in from the fresh air.

Modern asylum windows are so constructed that they can be locked open or shut. This is a great convenience to a nurse who has charge of the ventilation; because many patients regard an open window as a positive danger and shut it whenever they see one.

The importance of ventilation in an asylum cannot be overestimated, when we consider the dirty habits of a large number of the inmates, the unpleasant odour emitted by some of them and the frequency of phthisis (ten times that of the general population). The nurse must attend to the ventilation in his own interest as well as for the sake of his patients.

The mention of phthisis reminds me that I ought to say a word respecting the habit of spitting on the floor. This must be discouraged as sternly as possible. If a patient cannot avoid spitting, he must be provided with pieces of rag to spit into and these must be destroyed by burning. Boxes of suitable cotton rags can be obtained quite cheaply at any dental store, although they are not intended for this purpose. Whenever a nurse sees a spot of expectoration, he should wipe it up with a piece of rag (to be subsequently burned) and rub some carbolic or other antiseptic over the place.

This is the first time I have had occasion to refer to disinfection and it therefore appears to be a suitable

place for mentioning the case of catheters. Each ward should have its own supply of catheters and they should be kept in a special glass tubular receptacle, containing equal parts of glycerine and 1 in 500 perchloride of mercury. They are then always ready for immediate use, and, after use, may be washed with *cold* water and returned to the solution.

There are certain articles which it is considered inadvisable for mental patients to have among their possessions, chiefly such things as might be used for suicide. I have called them the contraband of lunacy. They are knives, scissors and other cutting or sharp-pointed instruments. Handkerchiefs are not allowed, for the reason that they may be used for purposes of strangulation. Similarly, tapes and strings must be forfeited. They must be cut from garments possessing them, and buttons and buttonholes substituted. Boots and corsets should be inspected every night to see that the laces have not been removed. Flannelette night garments should not be allowed, because the substance can be torn noiselessly and used for strangulation. Moreover, flannelette is said to be unduly inflammable.

I think that chess ought not to be allowed in the wards of an asylum. It is too strenuous a game, even for experts, and the mental strain undoubtedly prejudices recovery.

Lastly, I am sure that all mental nurses of experience will agree with me that Bibles, prayer-books and hymn-books have a detrimental influence on many patients and their distribution requires the strictest supervision.

## CHAPTER XIX.

### ENTERTAINMENTS. PRIVATE NURSING.

THE subject of entertainments perhaps belongs to the previous chapter. I have already spoken of amusements and entertainments in the wards ; but, in addition to these, most institutions for the insane provide what are called “ associated entertainments ” at which suitable patients from both male and female sides attend and associate with one another. During the winter months these are usually concerts, theatrical representations and dances. Among the patients, the dances are invariably the most popular.

It is usually left to the nurse to decide which patients may be allowed to go to an entertainment. Recent acute cases, of course, must not be sent, nor must patients suffering from extreme dementia, who hang their heads and take not the slightest interest in the proceedings. There are many chronic patients, however, who thoroughly enjoy and take a delight in the entertainments. Of course, these should be allowed to go ; it lightens their miserable lot in life.

Convalescents may also attend ; but a doubt occasionally arises in the nurse’s mind whether such and such a patient is well enough. To solve the difficulty I would suggest as a general rule, when in doubt, to let chronic patients go and convalescents remain and wait for another opportunity.

During the summer months, entertainments take the form of garden-parties or cricket matches. The former require the patients to be selected ; but the latter, at least when the cricket match is in the asylum grounds, allow nearly the whole asylum population to

turn out. Whether they take any interest in the proceedings or not, it is an afternoon in the open air, which cannot but be beneficial. If the nurse should happen to be in doubt about a certain patient on such days ; let him go !

On the occasion of any entertainment, summer or winter, it is for the nurse, who knows the patient better than anybody else, to decide whether he is well enough to attend or not. I have often, as superintendent, been surprised to see a patient, recently suffering from acute confusion, appear to my surprise at a dance, daintily dressed and evidently taking a pride in her appearance, and benefit from her experience.

It must be admitted that entertainments in time are apt to pall upon the staff of asylums. They get tired of them. So long as they are a pleasure to the nurses, as they are for the first few years, they go with a swing ; but when the pleasure becomes a pure duty, as it does in time, they are liable to fall flat. A nurse should, therefore, always keep up the appearance of enjoying the entertainments. At the dances he should mostly select patients as partners and at least appear to enjoy doing so. After all, the sense of duty in itself gives a certain amount of pleasure and self-satisfaction.

In conclusion a few words about private mental nursing. Here the nurse is left entirely to his own resources without doctor or other nurses to help him in case of difficulty. He is absolutely isolated, being a servant of the family, yet above the servants in the kitchen, with whom he should refuse to associate or gossip. He should endeavour to make himself a friend of the family, not of the servants. Everybody is suspicious of him, save the doctor. Some idea of this tendency may be gained from a recent case of my own, in which the lady of the house, a lady of title, insisted on being present whenever the patient, who was a male friend but no relation, was being cleansed after having soiled himself. The nurses very properly protested against such impropriety, but in vain and under

threat of dismissal, and the situation had to be accepted. Similarly, a good mental nurse knows that it is not only unkind, but also usually impolitic, to deceive a patient ; but interfering friends in a private house frequently insist on some quite unnecessary deception being kept up. Here again, the nurse has to make the best of a bad situation, report it to the doctor and get him to set matters right if he can.

In private nursing, even more than in public institution work, the friends commonly give more trouble than the patient ; but the nurse should endeavour to carry out in private exactly the same rules as I have set forth for asylum nursing. There are two matters which stand out prominently : one is that no risk of suicide should be run and the other is that the patient must be kindly treated. If the friends run counter to the nurse's wishes in any detail concerning these questions, he should report the matter to the doctor and resign the case.

Private cases should be nursed on the ground floor, unless there is no possibility of the patient throwing himself out of any of the windows to which he has access on an upper floor, and, in any case, windows should have a stop screwed to the frame, so that they cannot be opened more than five inches. This rule applies to the nursing of all delirious patients, whether their illness be primarily mental or physical.

Another important point is that the patient should not be able to secrete himself, even, nay especially, in the w.c. There must be no bolt on the door of the w.c. or of any other room to which the patient has access and the nurse must have charge of all keys, not only to doors, but also to cupboards where knives, etc., are kept.

It is almost needless to say that the nurse should keep a written record of all the patient's doings in the doctor's absence and that such record should be presented at the doctor's visit. One special advantage of such a record is that it inspires confidence among the friends and relations.

Lastly, the mental nurse should be a harbinger of mercy to the patient. Friends and relations are often too anxious to domineer over a mental patient and to restrict his liberty of action too much. This is a matter that can be tactfully readjusted by a mental nurse. He should become the patient's friend and champion against all intruders. By doing so, he will gain his patient's confidence and thus be enabled to manage him much more easily. In certain matters, such as the taking of rest and food, the nurse must be obdurate ; but, in a hundred details that do not matter, he should allow his patient as much liberty of action as possible. Sympathy goes a long, long way towards curing a mental patient.

## INDEX.

	PAGE.		PAGE.
Agnosia .. ..	19	Entertainments	93-94
Amentia .. ..	67-71	Epilepsy .. ..	50-58
Amnesia .. ..	21, 60	Escape .. ..	83
Aura .. ..	54	Excitement .. ..	32-35
		„ Treatment of	23
Baths .. ..	77-80	Faints .. ..	50
Beds .. ..	86	Feeding .. ..	72-76
Bedsore .. ..	62, 65	„ Cup .. ..	74
Bibles .. ..	92	Fits 50,-55, 60, 61	
Bolting food .. ..	62	Food .. ..	72-76
		Furor .. ..	56
Catheters .. ..	92		
Character of a mental nurse	13, 14, 85	General and Mental Nursing, compared	11, 12
Chess .. ..	92	General Paralysis	59-62
Choking .. ..	62, 69	Gourmands .. ..	76
Clothing .. ..	69, 87-88		
Collections .. ..	24	Hairpins .. ..	87
Confusion .. ..	19	Hallucinations	20, 48
„ epileptic .. ..	56	Handkerchiefs .. ..	92
Convulsions 50-55, 60, 61		Head Attendant .. ..	81
Cupboards .. ..	86	Hymn Books .. ..	92
		Hypermnnesia .. ..	21
Dandruff .. ..	44, 87	Hysteria .. ..	50, 51
Dangerous Patients			
10, 36-40, 66		Idiocy .. ..	67-71
Deformities .. ..	68	Illusions .. ..	19
Delirium, Epileptic .. ..	56	Imbecility .. ..	67-71
Delusions 20, 21, 46-49		Imperception .. ..	19
Dementia .. ..	63-66	Inactivity, Treatment of	24
„ præcox 33, 47, 64-65 76		Incoherence .. ..	26
Depressed patients 41-45		Insomnia .. ..	89-90
Diet for epileptics .. ..	72	Institutions for training .. ..	15-17
Dirty heads .. ..	87	Interest .. ..	43-44
„ patients .. ..	78		
Electric Baths .. ..	79		

	PAGE.		PAGE.
Knives ..	83, 92	" Refractory " ward	38
Lavatories ..	.. 86	Refusal of food	19, 44, 73
Masturbation ..	.. 25	Scurvy ..	.. 72
Meals ..	.. 88	Seborrhœa ..	.. 44
Medico-Psychological		Shower bath ..	.. 79
Examination ..	.. 15	Skin ..	.. 44
Memory, Loss of	21, 60	Sleep ..	.. 89-90
Moral training ..	.. 70	" Specials " ..	.. 30
Morons ..	68, 69	Strings ..	.. 92
Negativism ..	.. 25	Stupor, Epileptic	.. 56
Nicknames ..	.. 26	Suicide,	27-31, 83
Night Nurses	81, 84	" Prevention of	29
Noisiness	34, 35	Symptoms ..	.. 18
Nurses, Sick ..	.. 84	Syphilis ..	59, 68
Occupation ..	43, 44	Tapes ..	.. 92
Paramnesia ..	.. 22	Temperature of ward	86
Paranoia ..	.. 47	Tickets ..	.. 50
Peptonising ..	.. 75	Tube feeding	74, 75
Phthisis ..	.. 91	Ventilation ..	90-91
Prayer Books	.. 92	Violence ..	36-40
Private Nursing	94-95	" Treatment of	39-40
Prolonged bath ..	.. 78	Washing ..	25, 77-80
Rest ..	43, 89	Wet Pack ..	.. 79
		Whistle ..	.. 39
		Writing ..	.. 26

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